Patra

A craniosacral studio

The information requested below will assist the therapist in treating you safely. Please note that all information provided will be kept confidential unless allowed or required by law.

Your written permission will be required to release any information.

GENERAL INFORMATION

Name: _____

Parent/Guardian:_____

Mailing Address:

_____

_____

Cell: _____

Email: _____

Date of Birth: _____

How did you find Patra? I.e. Google/Upledger/Friend

_____

Were you referred by someone?

Name: _____

HEALTH CARE INFORMATION

Primary Care Physician name and number:

_____

_____

GENERAL HEALTH

Overall, how is your general health?

_____

_____

Why are you seeking CranioSacral Therapy? Please include the location of any tissue or joint discomfort.

_____

_____

_____

Are you currently receiving treatment from another health care professional or therapist? If yes, for what?

_____

Medications, supplements, herbs, essential oils etc.

_____

_____

Conditions being treated

_____

_____

_____

Injuries (recent or past)

_____

_____

Surgery (recent or past)

_____

_____

RESPIRATORY	Present	Past
Present Past Chronic cough	❑	❑
Shortness of breath	❑	❑
Bronchitis	❑	❑
Asthma	❑	❑
Emphysema	❑	❑
CARDIOVASCULAR		
High/ Low blood pressure	❑	❑
Chronic congestive heart failure	❑	❑
Heart attack/ Heart disease	❑	❑
Phlebitis/varicose veins	❑	❑
Stroke/CVA	❑	❑
Cardiovascular aneurysm	❑	❑
Pacemaker/other device	❑	❑
Coldness in extremities	❑	❑
DIGESTIVE CONDITIONS		
Crohn's disease	❑	❑
Diverticulitis	❑	❑
Irritable Bowel	❑	❑
Leaky Gut	❑	❑
Reflux	❑	❑

Please describe digestive issues:

_____

_____

Please cancel at least 24 hours in advance to avoid being charged for missed appointments.

OFFICE USE ONLY

Annual Update: _____ _____ _____ _____ _____

Patra

A craniosacral studio

The information requested below will assist the therapist in treating you safely. Please note that all information provided will be kept confidential unless allowed or required by law.

Your written permission will be required to release any information.

WOMEN	Present	Past
Gynecological Conditions	❑	❑
Birth Related Issues	❑	❑

Pregnant, due: _____

HEAD/NECK		
Headaches/Migraines	❑	❑
Jaw problems (pain/clicking/locking)	❑	❑
Whiplash	❑	❑
Vision problems or loss	❑	❑
Ringing in the ears	❑	❑
Fainting/ Dizziness	❑	❑
Sinus problems	❑	❑
Facial pain	❑	❑
Dental Surgery/Issues	❑	❑
Closed head injury	❑	❑
Other neurological conditions	❑	❑
Concussions (how many ___)	❑	❑
Post-Concussion Syndrome	❑	❑

Please provide detail:

_____
_____
_____

OTHER CONDITIONS	Present	Past
Epilepsy/seizures	❑	❑
Diabetes	❑	❑
Cancer: type_____	❑	❑
Arthritis	❑	❑
Susceptible to colds/infections	❑	❑
High stress levels	❑	❑
Insomnia	❑	❑
Fatigue	❑	❑
Nervousness	❑	❑
Numbness/tingling/loss of sensitivity	❑	❑
PDD/autism	❑	❑
Recurrent ear infections	❑	❑
Developmental delays	❑	❑
Behavioral issues	❑	❑
Hyperactivity/ADD/ADHD	❑	❑
Learning disabilities	❑	❑
Eye motor problems	❑	❑
Restlessness/sleep problems	❑	❑
Depression	❑	❑
Anxiety	❑	❑

Please provide more detail:

_____
_____
_____

Is there any other information your therapist should know?

_____
_____

Presence of internal pins, artificial joints, or special equipment:

_____
_____

Known allergies or hypersensitive reaction:

_____
_____

Other diagnosed diseases and medical conditions:

_____
_____

By signing below you agree to the following:

I have completed this form to the best of my ability and knowledge, and agree to inform my therapist if any of the above information changes at any time.

I am aware that the bodywork I receive is for relaxation purposes only. It is not intended to diagnose, treat, or cure. Any medical inquiries and/or treatments should be directed to a medical professional.

Cancellation Policy: **24 hour notice** must be provided to **avoid a $75 ($100 for 90min sessions) late cancellation** fee. Once this fee is paid, rescheduling will be permitted.

Printed Name: _____

Signature: _____

Date: _____

Please cancel at least 24 hours in advance to avoid being charged for missed appointments.

OFFICE USE ONLY

Annual Update: _____ _____ _____ _____ _____

Patra

A craniosacral studio

POLICIES

Please be advised of the policies for this office. Your signature below signifies acceptance of these policies.

Hours of Operation

Sessions are available on Tuesdays and Thursdays. First session at 11am and last at 4:30pm. Hours subject to change.

Cancellations & Rescheduling Policy & Fees

Your scheduled appointment is reserved **exclusively** for you. A text reminder will be sent to you 24 hours before your session. Should you need to cancel or reschedule, please notify me **at least 24 hours in advance**.

Any cancellations with **less than 24-hour** notice are subject to **a cancellation fee of $75 (or $100 for a 90 minutes session)**. Clients who miss their appointments without giving any prior notification will be **charged in full** for the scheduled service. These fees must be paid prior to scheduling another session.

Late Arrival Policy

All sessions have a specific time schedule. A late arrival may not receive an extension of time.

No Show Policy

Unanticipated events occur in everyone's life. Things happen that are out of our control. Please contact me if you are unable to keep your appointment, for any reason. Clients who miss their appointments without any prior notification may be charged in full.

Session Policies

Craniosacral Therapy does not require the removal of any clothing, shoes and glasses are suggested.

During Raindrop Technique, the client may choose to leave on as much clothing as needed for comfort. During the application of oils, only the feet and back need to be exposed during the session. The client will always be modestly draped. Only the area receiving oils will be undraped.

I am happy to adjust pressure, temperature, or music volume at the client's request.

Sexual interaction or discussion of any kind is **not tolerated** at any time. The session will be ended. Client will be responsible for full payment.

Session Discussion

All discussion during sessions will remain **confidential**. This is a safe place to express, share, and release.

New Medical Conditions

It is the **responsibility of the client** to keep me informed of any medical treatment. Please provide written permission from the physician to continue with Craniosacral Therapy or Raindrop Technique.

Keeping me informed of and changes in health conditions is also **required**.

Printed Name: _____ Date:_____

Signature: _____

Please cancel at least 24 hours in advance to avoid being charged for missed appointments.

OFFICE USE ONLY

Annual Update: _____ _____ _____ _____ _____