

# 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: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Cell: \_\_\_\_\_

Email: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

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

### HEALTH CARE INFORMATION

Primary Care Physician name and number:  
\_\_\_\_\_  
\_\_\_\_\_

### GENERAL HEALTH

Overall, how is your general health?  
\_\_\_\_\_  
\_\_\_\_\_

Why are you seeking CranioSacral Therapy?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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
Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Long Covid	<input type="checkbox"/>	<input type="checkbox"/>

### CARDIOVASCULAR

High/ Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Chronic congestive heart failure	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack/ Heart disease	<input type="checkbox"/>	<input type="checkbox"/>
Phlebitis/varicose veins	<input type="checkbox"/>	<input type="checkbox"/>
Stroke/CVA	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular aneurysm	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker/other device	<input type="checkbox"/>	<input type="checkbox"/>
Coldness in extremities	<input type="checkbox"/>	<input type="checkbox"/>

### DIGESTIVE CONDITIONS

Crohn's disease	<input type="checkbox"/>	<input type="checkbox"/>
Diverticulitis	<input type="checkbox"/>	<input type="checkbox"/>
Irritable Bowel	<input type="checkbox"/>	<input type="checkbox"/>
Leaky Gut	<input type="checkbox"/>	<input type="checkbox"/>
Reflux	<input type="checkbox"/>	<input type="checkbox"/>
Celiac Disease	<input type="checkbox"/>	<input type="checkbox"/>

Please describe digestive issues:  
\_\_\_\_\_  
\_\_\_\_\_

### WOMEN

	Present	Past
Gynecological Conditions	<input type="checkbox"/>	<input type="checkbox"/>
Birth Related Issues	<input type="checkbox"/>	<input type="checkbox"/>

Pregnant, due: \_\_\_\_\_

Please provide detail: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### HEAD/NECK

	Present	Past
Headaches/Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Jaw problems (pain/clicking/locking)	<input type="checkbox"/>	<input type="checkbox"/>
Whiplash	<input type="checkbox"/>	<input type="checkbox"/>
Vision problems or loss	<input type="checkbox"/>	<input type="checkbox"/>
Ringling in the ears/Tinnitus	<input type="checkbox"/>	<input type="checkbox"/>

**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.**

<b>HEAD/NECK – continued</b>	Present	Past
Fainting/ Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>
Facial pain	<input type="checkbox"/>	<input type="checkbox"/>
Dental Surgery/Issues	<input type="checkbox"/>	<input type="checkbox"/>
Closed head injury	<input type="checkbox"/>	<input type="checkbox"/>
Other neurological conditions	<input type="checkbox"/>	<input type="checkbox"/>
Concussions (how many ___)	<input type="checkbox"/>	<input type="checkbox"/>
Post-Concussion Syndrome	<input type="checkbox"/>	<input type="checkbox"/>

Please provide detail:

---

---

---

<b>OTHER CONDITIONS</b>	Present	Past
Epilepsy/seizures	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Cancer: type _____	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Susceptible to colds/infections	<input type="checkbox"/>	<input type="checkbox"/>
High stress levels	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Numbness/tingling/loss of sensitivity	<input type="checkbox"/>	<input type="checkbox"/>
PDD/autism	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent ear infections	<input type="checkbox"/>	<input type="checkbox"/>
Behavioral issues	<input type="checkbox"/>	<input type="checkbox"/>
Hyperactivity/ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>
Learning disabilities	<input type="checkbox"/>	<input type="checkbox"/>
Eye motor problems	<input type="checkbox"/>	<input type="checkbox"/>
Restlessness/sleep problems	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Joint Hypermobility/Ehlers–Danlos	<input type="checkbox"/>	<input type="checkbox"/>

Please provide more detail:

---

---

---

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

---

---

Known allergies or hypersensitive reactions:

---

---

---

Other diagnosed diseases and medical conditions:

---

---

Is there any other information Patra should know?

---

---

---

---

---

---

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 Patra 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 \$90 (\$130 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, Thursdays, and Fridays. Sessions on Tuesdays and Thursdays are 11am to 5pm, Fridays 12pm-5pm. Hours subject to change. Sessions can be booked with Patra or on her website [www.patrahealey.com](http://www.patrahealey.com).

**Audio Recording**: Sessions may be recorded for learning purposes only. All recordings will be kept confidential. You may refuse at any time. This is only being done for a short time while I complete my advanced certification. Recordings will be deleted after the certification is obtained. Thank you for your understanding.

### **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 Patra **at least 24 hours in advance** or follow your session text link.

Any cancellations with **less than 24-hour** notice are subject to **a cancellation fee of \$90 (or \$130 for a 90-minute 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**

Patra works with children ages 10 and up. Please contact Patra before scheduling a session for your child to determine if craniosacral therapy is appropriate.

If you have children, you will need to find someone to care for them during your session. **This is time set aside for you to focus on you.** Children are not permitted in the studio during sessions.

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

I am happy to adjust pressure, table 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 end immediately, and the client will be responsible for full payment.

### **Session Discussion**

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

### **New Medical Conditions**

It is the **responsibility of the client** to keep Patra informed of any medical treatment. Please provide written permission from the physician to continue with Craniosacral Therapy. Keeping Patra informed of any changes in your health is **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: \_\_\_\_\_