Soul Harmony Craniosacral Therapy

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2 ½ Beacon St. Suite 147

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Confidential Client Health History Information

Name:_____ Gender:_____ DOB:_____

Address:_____ City:_____ State:_____ ZIP:_____

Home Phone:_____ Cell Phone:_____

Email:_____

In case of emergency, contact:_____

Referred by:_____ Occupation:_____

Activities/Hobbies:_____

Exercise/Relaxation:_____

Have you ever had professional massage and bodywork? _____Yes _____No

If yes, what was your experience with this work?_____

Have you ever had craniosacral/zero balancing therapy? _____Yes _____No

If yes, what was your experience with this work?_____

What are your treatment goals?_____

Do you feel any pain or discomfort in your body today? ____ Yes ____No

If yes, is this pain or discomfort a chronic condition? ____Yes ____No

If yes, to either above, describe:_____

Are you currently under the care of a medical doctor/chiropractor/therapist/ or other health care professional?

If yes, describe:_____

What medications or supplements are you currently taking? _____

_____

Please describe any injuries, accidents, or serious illness in the last 3 years: _____

_____

Do you currently have, or have you ever had, any of the following conditions/illness/problems?

( ) Contacts **( )** Heart condition **( )** High/low blood pressure **( )** Diabetes **( )** Cancer **( )** Convulsions

( ) Blood clots/Phlebitis **( )** Muscle/joint/pain **( )** Circulatory problems **( )** Respiratory problems **( )** Fatigue

( ) Headache **( )** Migraine headaches **( )** Sinus problems **( )** Skin problems **( )** Lymphatic condition

( ) Osteoporosis **( )** Postural deviations **( )** Arthritis **( )** Tendinitis **( )** Numbness/tingling **( )** Varicose veins

( ) Digestive problems **( )** Depression **( )** Anxiety **( )** Allergies **( )** Vision problems **( )** Dentures or bridges

( ) Jaw pain/teeth grinding/TMJ **( )** Sleep difficulties/ insomnia **( )** Infectious diseases (describe)

( ) Autoimmune conditions (describe) **( )** Other conditions (describes)

Describe any conditions checked above, or not listed above: _____

_____

Client Consent

Please take a moment to carefully read the following information and sign at the button where indicated. By my signature here, I acknowledge that I have agreed to receive one or more massage, bodywork, zero balancing, craniosacral therapy therapy sessions and I understand that:

1. Massage, bodywork, zero balancing, craniosacral, and somatic therapies involve the manipulation of the soft tissue of the body through touch for the general purpose of relaxation, stress, reduction, relief from musculoskeletal tension or discomfort, improving circulation, and enhancing my overall sense of wellness.
2. Massage, bodywork, zero balancing, craniosacral and somatic therapies are not involved with the treatment of disease, illness or disorders of any kind, nor does it substitute for medical diagnosis or treatment when such attention is needed, Massage, bodywork and somatic therapies specifically *exclude* diagnosis, prescription, manipulation or adjustment of the human skeletal structure, or or any other service, procedure or therapy which requires a license to practice orthopedics, physical therapy, podiatry, chiropractic, osteopathy, psychotherapy, acupuncture, or any other profession or branch of medicine.
3. Under certain medical conditions, massage & bodywork may not be advised. I affirm that I have accurately stated all my known medical conditions and physical limitations to the massage therapist. I will inform my massage therapist of any changes to this information prior to receiving future massage, bodywork treatments. I understand that my information I share with the massage therapist will remain confidential. If a massage is potentially harmful to me, the therapist has the right to decline to do the treatment.
4. It is necessary for the massage therapist to touch and observe my body in order to provide massage and bodywork therapy. I am aware that massage work is most effective when performed directly on the skin with the use of lubricants, and that all areas of my body not being massaged will remain draped. I give the massage therapist permission to work on my body in such a way. I understand that my comfort level is most important and that I may choose how much clothing to remove for a session.
5. I understand that it is important to provide the massage therapist with honest feedback. I agree to provide feedback to the therapist about the effectiveness of the work, massage techniques that I enjoyed, massage techniques that I did not like, as I become aware of it. I will let my massage therapist know and understand that I may stop the massage and that I may refuse any massage methods.

6. I understand and agree that if I am late for an appointment the actual time will be reduced by the amount of time I was late and I will be responsible for the full payment of the scheduled session fee.
7. I understand and agree that if I need to cancel my appointment I will do so with 24 hours notice.
8. I understand and agree that all session fees are payable at the end of the session by **cash or check**. A processing fee of $35.00 may be charged and collected for checks on which payment has been refused.
9. I understand and agree that a massage therapy session may be terminated by the therapist for any inappropriate behavior, intoxication, infectious (e.g. COVID-19, flu, cold, etc) or sexual advances. I understand that massage is strictly non-sexual and the session will be terminated and payment for services will be rendered in full.

Client's Signature:_____ **Date:**_____

Consent for treatment of a minor

By my signature below, I hereby authorize my child:_____

To receive massage, bodywork, zero balancing, craniosacral, and somatic therapy techniques.

Signature of Parent/Guardian:_____ Date:_____