

Client Registration Form – Biodynamic Craniosacral Therapy

Personal Information

Name: _____ Preferred Pronoun: _____

Address: _____

City/Prov/Postal: _____

Email: _____ Phone: _____

Date of Birth: _____ Occupation: _____

Emergency Contact: _____ Phone: _____

Medical History

1. Are you currently under medical supervision? Yes No

If yes, please explain:

2. Are you currently taking any medication? Yes No

If yes, please list:

3. Please list any conditions that apply to you:

4. Is there anything else about your health history that you think would be useful to know:

If I _____ experience any pain or discomfort during this session, I will immediately inform the therapist so that the situation may be adjusted to my level of comfort and safety. I further understand that biodynamic craniosacral therapy should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that biodynamic craniosacral therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Signature of Client: _____ Date: _____