Young Adult Client Information (age 13-17) CranioSacral Therapy by Emily Klik, LMT CST.
Parent / guardian please fill in as applicable and sign on 2nd page. Thank you.

Name of minor client _____ DOB_____

Name of parent / guardian: _____

Address: _____City: _____State/ Zip: _____

Parent / guardian contact number/s: _____ Alternate:_____

Parent email contact: _____

Referred by: _____May I thank them? _____

Has the minor client received Craniosacral therapy in the past? Yes / No Date of last treatment: _____

For what condition/s? _____

What is the reason for this appointment today? (anxiety, headache, pain, concentration, injury, etc)

_____

_____

Does the patient have a medical diagnosis? _____

Is there any recent crisis or stressor happening that is significant to the minor client's development?

_____

_____

Is the minor client receiving any other intervention / treatment / therapy? Yes / No If so, please describe:

_____

_____

Has the minor client had corrective surgery for strabismus or other eye motor difficulties? Y / N

Please list any surgical procedures, including dental, appendectomy, cyst removal, ENT procedures, etc:

_____

_____

Other relevant medical history. Please circle any of the following which apply to minor client; indicate past conditions with a "P"

Allergies	Chiari-	Fracture spine / skull*	Pregnant
Aneurysm*	-malformation*	Headache	Rheumatoid-
Arthritis	Chronic pain	Heart condition	-arthritis*
Asthma	Clenching / grinding	Joint disease	Rib pain
Back pain	Depression	Joint replacement	Sciatica
Balance problems	Diabetes	Long covid	Scoliosis
Blood clots	Difficulty swallowing	Loss of taste/ smell	Seizures
BP high / low	Dizziness / vertigo	Migraine	Sinus issues
Braces / retainer	Ear noises / popping	Neck pain	Sleep issues
Brain fog	Ehlers-Danlos	Numbness	Spinal pain
Cancer	Epidural leaks*	Osteoporosis*	Stress / anxiety
Cerebral-	Fibromyalgia	Pacemaker	Stroke*
-hemorrhage*	Fibrotic cysts	Poor circulation	TMJ issues / pain

Please list any additional information, observations, symptoms, or health history that is relevant or significant to this therapy. Including precautions, allergies, sensitivities, preferences, etc.

_____

_____

CONSENT FOR CARE

You have the right to seek a second opinion or to end the therapy session at any time. You are entitled to information about the methods and techniques used in the evaluation/treatment. You may also ask the therapist for information about their training and credentials.

I, _____, understand that CranioSacral Therapy is not a substitute for standard medical care, and I have indicated all of the minor client's medical conditions. I will alert the practitioner to any changes in their health status, including medication changes. It is my choice to authorize the minor client to receive CranioSacral Therapy with an understanding of the risks and benefits, I release and hold harmless Emily Klik from any present and future claims. I understand that there is no stated guarantee for the effectiveness of treatment. I voluntarily agree to assume responsibility for those risks, and I give my consent for treatment for the minor client.

Parent/ guardian signature_____Date_____

PAYMENT POLICY

Full payment is due at the time of service, unless other arrangements have been made in advance. Fee is $100 per session. All sessions are scheduled for 60 minutes. There may be an additional fee for a house call that includes table setup and travel time. Late arrivals cannot be guaranteed an extension of scheduled treatment time, and will be responsible for full fee. Please make any cancellations or schedule changes 24-48 hours in advance when at all possible (exceptions for illness and weather-related events); cancellations within 24 hours will be subject to a $60 cancellation fee at therapists' discretion.

Parent/ guardian please initial understanding of payment policy: _____