Child / Pre-teen (age 4-12) CranioSacral Therapy by Emily Klik, LMT CST

Parent guardian please fill in as applicable and sign the 2nd page. Thank you.

Name of minor client_____ DOB _____

Name of parent / guardian _____

Address _____City _____State/Zip _____

Parent cell phone _____Other contact number _____

Parent email contact_____Referred by _____

Has the minor client received Craniosacral therapy in the past Y / N Date of last treatment: _____

For what condition/s _____

Please describe the reason for this appointment. (development issue, headache, injury, sinus issues etc)

_____

_____

Please circle any that apply:

Vaginal birth	Epidural	Premature birth	Tongue tie ~ revised
C-section	Vacuum	IVF/ IUI	Lip tie up/ low ~ revised
VBAC	Forceps	Latch/ suck issues	Buccal tie R / L / B ~ revised
Induced birth	Long labor _____	Newborn jaundice	
Stress/ anxiety	Sinus issues	Dizziness / Vertigo	Loss of taste/ smell
Brain fog	Speech / swallowing issues	Clenching / grinding / TMJ	Braces/ palate expander
Sleep issues	Balance issues	Tinnitus/ ear noises	Long-covid
Stroke	Aneurysm	Epidural leaks	Osteoporosis
Cerebral hemorrhage	Fracture of spine or skull	Chiari Malformation	

Does the minor client have a medical diagnosis? _____

_____

Please describe any recent or current crisis or stressor 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 any other eye-motor difficulties? Y / N

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

_____

_____

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: _____