Embody Your Health

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CRANIOSACRAL & SOMATIC EXPERIENCING INTAKE FORM

Name:_____ Today's Date:_____

Age: _____ Birthdate: _____

Which pronouns do you use: She/her He/him They/them Other: _____

Phone number: home _____
cell _____

Email address: _____

Emergency contact

Name: _____

Phone number: _____

Relationship: _____

Who referred you to me/how did you hear about me?

_____

_____

What is your occupation?

_____

Are you pregnant? _____ Yes _____ No If Yes, what is your due date? _____

What tools, practices and activities do you use to relieve stress and maintain your wellbeing?

_____

_____

_____

Where in your body do you hold tension?

_____

Is this your first Craniosacral Therapy session? _____ Yes _____ No

What prompted you to schedule this session?

_____

_____

_____

_____

Any medical diagnoses or health concerns?

_____

_____

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_____

Any accidents, abuse, or trauma history? Include approximate dates.

_____
_____
_____
_____
_____

Any injuries and/or surgeries? If so, name the surgery & the approx. date of surgery.

_____
_____
_____
_____
_____

Allergies/sensitivities to essential oils or other scents?

_____
_____

What are your goals/intentions for our work together?

	Pain Relief		Boost Immune Function		Healing
	Relaxation		Inner Exploration		Curiosity
	Sleep Better		Mental		Emotional Release
	Therapeutic		Focus/Meditation		Expand Knowledge of Craniosacral Therapy
	Increase Ability to Receive Healthy Touch		Mind/Body Awareness		Other (please list):

INFORMATION REGARDING FEES, APPOINTMENTS, AND CRANIOSACRAL THERAPY

Location:

Holistic Healing Center
5700 Ralston St,
Suite 110,
Ventura,
CA 93003

What to expect: See bridsimon.com for more information.

What to wear: Come in comfortable clothing, you will be fully clothed throughout the session and will be asked to remove your shoes before getting onto the table.

Session Fees and Length:

A 60-minute appointment includes a 40 to 45-minute BCST session, and is $ 125

An 90-minute appointment includes a 60 to 70-minute BCST session, and is $ 355

Cash, Check, & Card are accepted. There is a 3% charge on card transactions. Payment is expected at the time of your session.

Fees are subject to change. Clients will be given at least one week of notice before fees increase.

Disclaimers:

I understand that the craniosacral therapy I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during my session, I will immediately inform the therapist so that the pressure and/or hand placement may be adjusted to my level of comfort.

I further understand that craniosacral therapy should not be construed as a substitute for medical examination, diagnosis or treatment and that I should see a qualified medical specialist for any mental or physical ailment that I am aware of. I understand that 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.

Because craniosacral therapy should not be performed under certain medical conditions 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.

If I am experiencing a mental or physical health emergency, I will seek immediate medical care.

If I make any sexual advancements or innuendos during any of my sessions, the session will be terminated immediately without a refund, and I will not be permitted to return. If I made any sexual advancements or innuendos in any of my communication with Bríd , my status as a client will be terminated immediately.

Appointment and Cancellation policy:
If you are late for an appointment, it may not be possible to change the ending time of the session, but you will still be responsible for payment in full of the scheduled session. Furthermore, you agree to give notice of appointment change or cancellation at least 24 hours in advance of your scheduled appointment. Please note: If you do not give such notice, or do not show up for your scheduled appointment, you assume responsibility for payment in full of the scheduled session. Exceptions may be made at my discretion in the case of unforeseen illness or emergency.

I collect credit or debit card numbers in case I need to charge for a missed appointment. I will never charge your card unless the policy as stated above is violated. I will always notify you before charging your card.

Name on card: _____

Card number: _____

Expiration date: _____

CVV code: _____

Zip code: _____

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By signing below, I affirm the accuracy of the information I have provided and understand and agree to the policies above.

_____ _____

Printed Name Date

_____

Client's Signature

_____

Signature of Parent or Guardian if under 18
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