HeartSpace
NATURAL MEDICINE

Pediatric Craniosacral Therapy Intake Form

Last Name: ..... First Name: ..... MI: .....

Birthdate: ..... Gender: .....

Parent/Guardian: ..... Email: ..... Phone: .....

Parent/Guardian: ..... Email: ..... Phone: .....

Mailing Address: .....

City: ..... State: ..... Zip Code: .....

Please List Any Life Threatening Allergies: .....

Referred to Dr. Emily Telfair by: .....

CURRENT HEALTH CARE TEAM

Patient's Pediatrician: ..... Phone: .....

Specialist: ..... Specialty: ..... Phone: .....

Specialist: ..... Specialty: ..... Phone: .....

OTHER HEALTH CARE TEAM MEMBERS *(massage therapist, nutritionist, acupuncturist, etc.)*

Practitioner: ..... Specialty: ..... Phone: .....

Practitioner: ..... Specialty: ..... Phone: .....

CURRENT HEALTH CONCERNS (Please list your primary health concerns in order of importance.)

CONCERN **ONSET** **TREATMENT**

1. .....

2. .....

Have the patient ever received Craniosacral Therapy? Y / N If yes, when was their last treatment? .....

What are your goals for this visit? .....

.....

PATIENT'S MEDICAL HISTORY

Please list all current medications, supplements, herbal remedies, etc.: .....

.....

Please list any surgeries, accidents/injuries, major illnesses/hospitalizations (with dates): .....

.....

Today's Date: .....

Please mark any of the following the patient has now or has significant history of in the past. If a choice is given, circle one.

GENERAL

Now	Past	Comments
☐	☐	Headaches
☐	☐	Pain
☐	☐	Sleep Disturbance
☐	☐	Fatigue
☐	☐	Sinusitis
☐	☐	Other

MUSCLES AND JOINTS

Now	Past	Comments
☐	☐	Bone or Joint Disease
☐	☐	Osteoporosis
☐	☐	Broken Bones
☐	☐	Tendonitis/Bursitis
☐	☐	Arthritis
☐	☐	Scoliosis
☐	☐	Disc Problems
☐	☐	Sprain/Strain
☐	☐	Jaw Pain/TMJ
☐	☐	Neck/Shoulder/Arm Pain
☐	☐	Hip/Low Back Pain
☐	☐	Knee/Ankle Pain

NERVOUS SYSTEM

Now	Past	Comments
☐	☐	Head injuries/Concussions
☐	☐	Dizziness/Ringing in ears
☐	☐	Numbness/Tingling
☐	☐	Sciatica/Shooting pains
☐	☐	Pinched Nerve
☐	☐	Bell's Palsy
☐	☐	Other

ENDOCRINE SYSTEM

Now	Past	Comments
☐	☐	Diabetes
☐	☐	Thyroid Condition
☐	☐	Other

RESPIRATORY/CARDIOVASCULAR

Now	Past	Comments
☐	☐	Heart Condition
☐	☐	Blood Clots
☐	☐	High/Low Blood Pressure
☐	☐	Stroke
☐	☐	Irregular Heart Beat
☐	☐	Poor Circulation
☐	☐	Edema/Swollen Ankles
☐	☐	Chest Pain/Short of Breath
☐	☐	Asthma

DIGESTIVE/ELIMINATION SYSTEM

Now	Past	Comments
☐	☐	Constipation/Diarrhea
☐	☐	Gas/Bloating
☐	☐	Irritable Bowel Syndrome
☐	☐	Gastric Ulcers
☐	☐	Bladder/Kidney Dysfunction
☐	☐	Other

REPRODUCTIVE

Now	Past	Comments
☐	☐	Pregnancy
☐	☐	Menstrual problems
☐	☐	Prostate problems
☐	☐	Other

OTHER

Now	Past	Comments
☐	☐	Cancer
☐	☐	Anxiety/Stress
☐	☐	Tobacco Use
☐	☐	Drugs
☐	☐	Alcohol
☐	☐	Other

I understand that Craniosacral Therapy is not a substitute for standard medical care and I have indicated all of my known medical conditions for my child above. I will alert the practitioner to any changes in my child's health status. I hereby give consent for my child to receive Craniosacral Therapy with an understanding of the risks and benefits. I understand that there is no stated guarantee for effectiveness of treatment. I understand that my child's records will be kept in strict confidence.

PAYMENT POLICIES

Full payment is due at the time of service. Dr. Telfair requests 24-hours notice for canceling or rescheduling appointments. For any visits canceled with less than 24-hours notice, the client will be charged half of the original visit fee except in the case of family or medical emergency. This charge will be applied to the following visit or billed directly to the client. Late arrivals will not receive an extension of scheduled service times and will be responsible for full service fee. In the event legal action is required to collect payment, I agree to be responsible for attorney fees and costs.

Signature: ..... Date: .....