Release Form – CranialSacral Balancing Therapy

Name _____ **Age**_____

Address _____ **Home #** _____

General Health _____ **Range of Motion** _____

Do you have high blood pressure? Yes No **Are you pregnant?** Yes No

Describe any memorable accidents or traumas and age at occurrence. _____

_____

What is your intention for this session? _____

Please check any of the following that might be part of your intention:

___ General relaxation & balancing
___ Relieve migraine and tension-type headaches
___ Relieve TMJ - temporo-mandibular joint pain and other facial pain issues
___ Relieve neck, shoulder or lower back pain
___ Resolve post-traumatic injuries of the head and neck
___ Resolve psychological and/or emotional injuries
___ Relieve generalized challenges such as fibromyalgia and chronic fatigue syndrome
___ Desire to increase alertness, concentration and memory
___ Desire to reduce anxious behavior and stress related concerns

Contraindications for cranialsacral therapy:
Cranialsacral therapy generally involves no more than five grams of pressure – roughly the weight of a nickel. This gentle touch is one of the primary reasons CST is such a viable complementary care option for people of all ages and conditions. There are a few contraindications for cranialsacral therapy. Specifically, they are acute intracranial hemorrhage, intracranial aneurysm, recent skull fracture, or herniation of the medulla oblongata – in essence, any physiological condition in which slight changes in intracranial pressure could have a negative effect.

By signing below, I ensure that I understand that cranialsacral therapy, like other complementary approaches, is NOT a replacement for standard medical treatments. If I am under a physician's care for any condition, I have my primary care physician's consent to participate in this activity, which can involve slight changes in intracranial pressure.

I understand the service provided by the practitioner below is designed to be an educational experience and in no way takes the place of medical evaluation, care or advice. I understand that information exchanged is educational in nature and is intended to help me become more familiar and conscious of my own healing and well-being. I understand that if I feel medical interventions are necessary and/or I have questions regarding evaluation, diagnosis and/or treatment of conditions, I am to check with my physician.

_____

Recipient's Signature Recipient's Printed Name Date

Emergency Contact: _____ Phone:_____

Therapist's Name: _____