Spirit of Healing
5115 Olentangy River Rd
Columbus, OH 43235
Ph: 614-326-3504/ Fax: 614-326-3509

CST/LDT/Intuitive Healing/Somenos/Pregnancy Intake Form

Name: _____ Date of Birth: _____ Current Age: _____

Parent/Guardian Name: (if client is under 18)_____

Address:_____City:_____State:_____Zip:_____

Phone Number: ( ) _____ Occupation: _____

Email: _____

Your Physician's Name: _____Your Physician's Phone Number: ( ) _____

You were referred by: _____

Your description of the problem(s) that brought you here: _____

_____

What results do you hope to get from your session(s) here? _____

_____

Are you currently seeing a medical practitioner? ___ Yes ___ No If yes, please explain: _____

_____

List any medications that you are currently taking, including aspirin, ibuprofen, other over the counter drugs, prescription drugs, herbs, homeopathics, botanicals, aromatherapy, etc: _____

_____

Are you currently seeing a psychotherapist, counselor, psychiatrist, of psychologist? ___ Yes ___ No If yes, please explain: _____

Have you had any surgeries? ___ Yes ___ No If yes, what, why, and when? _____

_____

Have you had any accidents? ___ Yes ___ No If yes, what type and when? _____

_____

Have you had or do you currently have a chronic illness? ___ Yes ___ No If yes, what and when? _____

_____

Do you currently suffer from an infectious disease? ___ Yes ___ No If yes, what: _____

_____

Do you have a history of bleeding or clotting disorders, seizures, aneurysm, stroke, or heart attack? ___ Yes ___ No
If yes, what and when? _____

Are you pregnant? ___ Yes ___ No If yes, how far along are you? _____

Is there anything in your health history or family health history that we should be made aware of prior to working with you? ___ Yes ___ No If yes, what: _____

_____

_____

I understand that CranioSacral Therapy, Lymphatic Drainage, Somenos Process Work, Intuitive Healing, or Pregnancy Support is not to be construed as a substitute for medical examination, medical diagnosis, or medical treatment, and that I should see a physician, chiropractor, or other qualified medical practitioner if needed.

I understand that the CranioSacral Therapy practitioner is not qualified to perform spinal or skeletal adjustments. I understand that the CranioSacral Therapy, Lymphatic Drainage, Somenos Process Work, Intuitive Healing, or Pregnancy Support practitioner is not qualified to make medical diagnoses, or make medical prescriptions, and that nothing said in the course of the session(s) should be construed as such.

Because there are certain medical conditions in which CranioSacral Therapy or Lymphatic Drainage should not be performed, I affirm that I have stated all of my known medical conditions and answered all questions honestly and completely. I agree to keep the CranioSacral Therapy, Lymphatic Drainage, Somenos Process Work, Intuitive Healing, or Pregnancy Support practitioner updated as to any changes in my medical profile and I understand that there shall be no liability on the CranioSacral Therapy, Lymphatic Drainage, Somenos Process Work, Intuitive Healing, or Pregnancy Support practitioner's part should I fail to do so.

I give my permission for information from my session(s) to be used for educating other health care practitioners. I understand that my name will not be used and that such sharing will demonstrate utmost respect for me. I also give my permission for information regarding my session(s) to be sent to my health care providers and to my insurance company.

A CranioSacral Therapy, Lymphatic Drainage, Somenos Process Work, Intuitive Healing, or Pregnancy Support session usually includes hands-on assessment and treatment by one or more CranioSacral Therapy, Lymphatic Drainage, Somenos Process Work, Intuitive Healing, or Pregnancy Support practioner(s). I give my permission for the CranioSacral Therapy, Lymphatic Drainage, Somenos Process Work, Intuitive Healing, or Pregnancy Support practitioner(s) to perform such assessment and treatment. I also give my permission for the use of appropriate equipment (like bolsters, blankets, etc) to be used in the session as an aid to the practitioner or to ensure my comfort.

_____ _____

Date Client Signature (if a minor, parent or guardian's signature)

_____ _____

Date Practitioner's Signature