

Massage/ CranioSacral Therapy In-Take Form

Personal Information

Today's Date _____

Name _____ D. o. B. _____

Address _____ email: _____

City _____ State _____ Zip _____

Best Telephone No. _____

Occupation/ activities(e.g. heavy lifting, sitting, etc.) _____

Stress Level (1-low - 10-high) Personal _____ Professional _____

Do you exercise? _____ How often? _____ What type? _____

How did you hear about me? _____

Medical History

Are you currently under the care of a health practitioner? _____

Current Health Issues? _____

Past surgeries? _____

Any Allergies? _____

About Massage/ CranioSacral Therapy

Have you ever had a massage or craniosacral therapy? _____

If yes, was there anything you particularly liked/ disliked about it?

Are you currently experiencing any areas of tension/ pain in your body?

Any areas of your body you wish not to have massaged?

Is there anything else you feel would be helpful for me to know?

(continued on back)

Rates & Policies

Massage/ Craniosacral Therapy

Initial Appts. minimum 90mins \$140

General 60 minutes \$100 75minutes \$120 90 minutes \$140

*Home Visits for massage are available only under extenuating circumstances such as bed rest, hospital rest, etc.

60 min. \$150

90 min. \$170

In-home Infant CST session 60min. \$150

Partner Instruction for Prenatal Support at Home

90min. \$170

Payment of Services

Payment is due at the time of service. Cash, check and credit cards accepted.

A returned check will result in a \$25 fee.

Arriving Late

In the event that you arrive late for your treatment, you will be given the remaining time allotted for your session. You will be charged the full price of your session. It is my hope that you will be on time for your session so that you may receive full benefit.

Cancellations

I require 24 hours notice of cancellations or appointment rescheduling. If 24 hours notice is not given, you will be charged the full fee of your treatment.

This does not apply to expectant mother's in cases of medical emergency or labor but must be accompanied by a doctor's note to avoid being charged.

Please sign below stating that you understand and agree to adhere to the policies listed above.

Name _____ Date _____