

Unburdened Bodywork

Craniosacral Intake Form

CHILDREN UNDER 12

Legal Name: _____

Preferred Name: _____

Address: _____

Today's date: _____

Preferred contact method:

- Telephone
- Text
- Email

Best Phone # _____

DOB _____

PARENT'S Email: _____

Age: _____

Major concerns: _____

In case of emergency, please notify: _____ Phone _____

I, _____, (parent of minor child) understand that massage therapy is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation, and offer a positive experience of touch. The general benefits of massage, contraindications, and treatment procedure have been explained to me. I understand that bodywork is not a substitute for medical treatment or medications. I understand that the therapist does not diagnose illness, does not prescribe medication, and that spinal manipulation is not part of the therapy.

I understand it is my responsibility to inform the therapist of all known medical conditions and medications, as well as keeping the therapist informed of any changes. I understand that there shall be no liability on the part of the therapist due to my forgetting to relay any pertinent information.

I understand that it is my own responsibility to communicate with the therapist if I feel any pain or discomfort during the session so that the treatment can be adjusted.

Parent signature: _____

Date: _____