Bloom into Balance LLC

Craniosacral Therapy, Myofascial Unwinding and Reiki

Client Information

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In case of emergency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

General and Medical Information

❑ Yes ❑ No Do you experience frequent headaches?

❑ Yes ❑ No Are you pregnant?

❑ Yes ❑ No Are you wearing contact lenses?

❑ Yes ❑ No Are you diabetic?

❑ Yes ❑ No Do you have high blood pressure?

❑ Yes ❑ No If yes to previous question, are you taking medication for it?

❑ Yes ❑ No Are you epileptic?

❑ Yes ❑ No Have you ever had surgery?

❑ Yes ❑ No Have you had any broken bones in the past two years?

❑ Yes ❑ No Do you have tension or soreness in a specific area?

❑ Yes ❑ No Do you have cardiac or circulatory problems?

❑ Yes ❑ No Do you suffer from back pain?

❑ Yes ❑ No Do you have numbness or stabbing pains anywhere?

❑ Yes ❑ No Please list any accidents, falls, or other trauma you have experienced.

❑ Yes ❑ No Are you very sensitive to touch or pressure in any area? If there is an area you prefer not touched please list below

❑ Yes ❑ No Do you know anything about your own birth? If so, please explain.

❑ Yes ❑ No Do you have any other medical condition I should be aware of?

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Reiki Treatment

Have you ever had a Reiki session before? Yes\_\_\_\_\_\_ No \_\_\_\_\_\_\_

If yes, please tell me about your experience (when, what was it like, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you have a particular reason you are seeking Reiki treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please take a moment to carefully read the following information and sign where indicated.

If you have a specific medical condition or specific symptoms, tissue work/craniosacral therapy may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

I understand that the craniosacral therapy/myofascial release, henceforth CST,/Reiki I receive is provided for the basic purpose of relaxation and relief of muscular/connective tissue tension. If I experience any pain or discomfort during any session, I will immediately inform the practitioner so that the pressure and or/strokes may be adjusted to my level of comfort. I further understand that CST/Reiki should not be construed as a substitute for medical examination, diagnosis, or therapy treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailments that I am aware of. I understand that CST practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because CST/Reiki should not be performed under certain medical conditions. I affirm that I have stated all my known medical conditions, and answered all questions honestly.

I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner’s part should I forget to do so. I agree to comply with the cancellation policy which requires 24 hours’ notice for any rescheduled or cancelled appointment\*. If it is not possible to provide 24 hours’ notice, I will be responsible to pay the posted fee.

\*COVID-19 addendum: I certify that I will not come to any appointments if I or an immediate member of my household are exhibiting COVID-19 symptoms and that I will alert the practitioner before our appointment as soon as possible. I understand that I will not be charged for my appointment but that I will make every attempt to reschedule/cancel my appointment before the 24-hour window of my appointment time. In addition, I understand that the practitioner will make every attempt to keep a clean, safe office space and will not see patients if she or an immediate member of her household is ill and that she will alert me of the cancelled appointment as soon as possible. I release the practitioner (Laura Hanstad) of any and all liability if I become ill after an appointment.

Client name (print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_