BIODYNAMIC CRANIOSACRAL THERAPY CLINICAL PRACTICUM CLIENT INTAKE FORM

Date:_____ **Appointment Time:** _____:_____AM PM

Title: _____ **Preferred Pronouns:** _____

Last Name: _____

First Name: _____ **Middle Initial:** _____

Suffix: _____ **Birth Date**_____/_____/_____ **Birth Chromosomes:** XX XY

Street Address_____

Apartment/Suite: _____

City: _____**State:** _____ **Zip Code:** _____

Preferred Phone Number: _____ **Secondary Phone Number:** _____

Email Address: _____

Emergency Contact:

Name: _____

Relationship: _____ **Phone Number:** _____

Occupation:

Title: _____ **Time in Position:** _____

Please circle which most applies to the physical demands of your occupation:

Sedentary *(office administration, telecommunications, computer engineering, web design, food delivery)*

Low-Activity *(barbers/hairdressers/stylists, teachers/instructors, chemists, hotel/motel/resort desk clerks)*

Moderate Activity *(food service/waiting tables, custodial, warehouse, package delivery, roofers, lab work)*

High Activity *(HVAC, heavy equipment operators/mechanics, occupational therapy, linemen, contracting)*

Intense Activity *(construction, healthcare professionals, professional athletes, community & social services)*

Referred By:

Name: _____

Relationship: _____ ***Are they an existing Moonwing Client?:*** *Yes No Not Sure*

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Health History:

Please advise which conditions apply to you by filling in the corresponding bubble:

Cardiovascular

- O Congestive heart failure
- O Embolism
- O Heart attack
- O Heart disease
- O Hemophilia
- O High blood pressure
- O Low blood pressure
- O Pacemaker
- O Phlebitis
- O Poor circulation
- O Stroke
- O Thrombosis
- O Varicose veins
- O Family history

Head & Neck

- O Dizziness
- O Ear problems
- O Headaches
- O Hearing loss
- O Jaw pain (TMJ)
- O Migraines
- O Vision loss
- O Vision problems

Musculoskeletal

- O Arthritis
- O Artificial joint
- O Bursitis
- O Osteoporosis
- O Surgical pin/wire
- O Tendonitis

Neurological

- O Epilepsy
- O Multiple sclerosis
- O Numbness/tingling
- O Sensory loss/change
- O Sciatica
- O Seizures

Respiratory

- O Asthma
- O Bronchitis
- O Chronic cough
- O Emphysema
- O Shortness of breath
- O Sinusitis
- O Smoker
- O Tuberculosis
- O Family history

Reproductive

- O Given birth
- O Gynecological problems
- O Pregnant

Skin

- O Bruise easily
- O Skin conditions
- O Skin infections
- O Skin irritations

Miscellaneous

- O Anxiety
- O Cancer
- O Depression
- O Diabetes
- O Digestive conditions
- O Fibromyalgia
- O HIV/AIDS
- O Stress
- O Other

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Please rate your general health by circling the most appropriate image on the scale below:

Awful ***Alright*** ***Average*** ***Great*** ***Immaculate***

Please select a number from the scale so we may best plan your treatment (using '0' as none and '10' as high):

- ***Your level of pain? 1 2 3 4 5 6 7 8 9 10***
- ***Your level of stress? 1 2 3 4 5 6 7 8 9 10***
- ***Your quality of sleep? 1 2 3 4 5 6 7 8 9 10***
- ***Your quality of digestion? 1 2 3 4 5 6 7 8 9 10***
- ***Your sense of physical wellbeing? 1 2 3 4 5 6 7 8 9 10***
- ***Your sense of emotional wellbeing? 1 2 3 4 5 6 7 8 9 10***
- ***Your sense of mental wellbeing? 1 2 3 4 5 6 7 8 9 10***
- ***Your overall sense of wellbeing? 1 2 3 4 5 6 7 8 9 10***

Are you sensitive to light touch in any areas?

What helps you feel safe, well, and joyful?

What is your intention with receiving this work?

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Please describe any focus areas that you would like addressed during your treatment. Please describe the issue, its intensity and frequency, its impact to your everyday life, and whether you have already received treatment (if so, what treatment(s), when, and what were the results?):

Please describe any recent injuries, and whether you have already received treatment for them (if so, what treatment(s), when, and what were the results?):

Please list all over the counter, prescription medications, and recreational drugs that you are currently using:

Are you currently pregnant, and if so, what trimester, what symptoms and complications are you experiencing, and has your primary care provider approved therapy?

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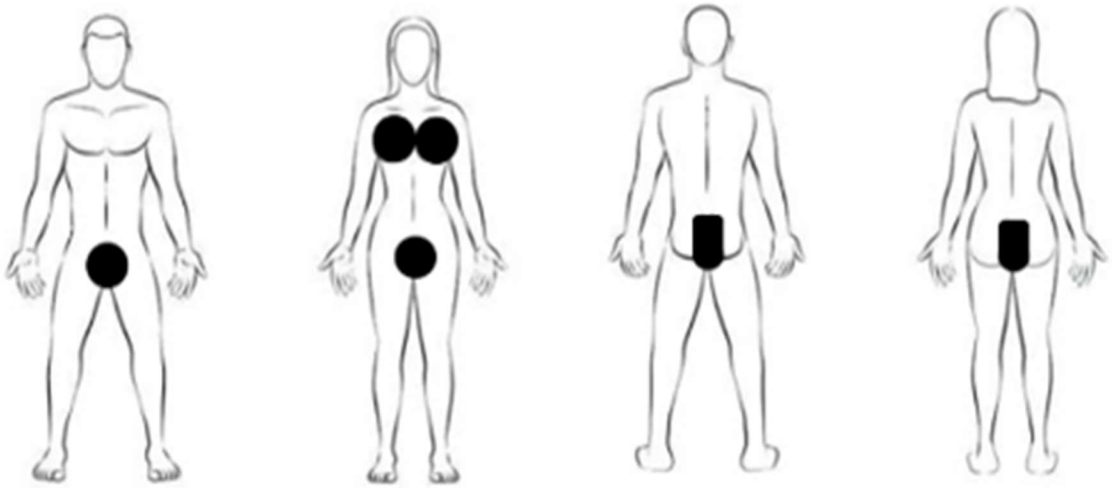
Please circle areas of the body that you are feeling sensations of restriction, congestion, blockage, or discomfort:



Trauma Informed Container Commitment

Moonwing Massage, PLLC commits to providing a trauma informed container. This means that we consider our space, our staff, and our therapists as trauma informed, such as but not limited to: Providing a safe space for those with physical and psychological disease, illness, and trauma. We commit to operating in consideration of each client's unique needs to provide the necessary and appropriate safe space, as required in real-time. Prior to each appointment, please update your therapist or the business of any changes to your needs, as it relates to providing you the most appropriate access to care and comfort for treatment.

Pricing Policy – Please read and initial the statements below to acknowledge understanding of the policy.

_____ *I understand that student-level sessions are free of charge, however there will be a price associated upon professional registration.*

Cancellation, Rescheduling, and Late Fees Policy – Please read and initial the statements below to acknowledge understanding of the policy.

_____ *I agree to inform my therapist of schedule change requirements as soon as possible, via email to MoonwingMassage@Outlook.com, or text to 618.444.8986.*

Privacy Policy – Please read and initial the statements below to acknowledge understanding of the policy.

_____ *I understand that my therapist and the staff at Moonwing Massage, PLLC, will abide by HIPAA (Health Insurance Portability & Accountability Act) law to properly maintain, protect, and keep private my sensitive personal information, including but not limited to my health history and documentation, contact information, and personally identifiable information. I know that my information will be shared only in extenuating and legally approved circumstances, such as but not limited to occasions where my information may be requested and shared with other healthcare providers upon receipt of the appropriate release documents and/or by mandatory compliance with court subpoena.*

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Liability Waivers – Please read and initial all statements below to become a Client of Moonwing Massage, PLLC:

_____ *I understand that this client intake form is solely for the free Biodynamic Craniosacral Therapy Student Clinical Practicum hours, and not for professionally licensed Massage Therapy treatments.*

_____ *I understand that clinical practicum is being completed at student level, and that my treatments may change over time to incorporate new techniques that may be appropriate for my current needs.*

_____ *I understand that body and energy work are not a substitute for necessary medical care and that my therapist is not qualified to diagnose, prescribe, or treat physical illness &/or mental wellness.*

_____ *I understand that I have the right to share direct and open feedback with my therapist if what they are doing feels uncomfortable or is not working for me. I will not hold my therapist responsible for discomfort I feel during or after a session.*

_____ *I know that I have the right to halt a therapy session at any time that I become uncomfortable, by simply asking my therapist to change their pressure, move to a different part of my body, or completely stop the session.*

_____ *I affirm that I have thoroughly described my medical conditions and medications, recent injuries, and areas on my body that I would like avoided, within this intake form.*

_____ *I agree to keep my therapist informed of any health, medication, and injury changes prior to each appointment. I will not hold my therapist responsible for adverse effects of treatment in the event that I did not properly update them prior to treatment.*

_____ *I have received, read, and understand the Trauma Informed Container Commitment.*

_____ *I understand that I have the right to copies of my client files at any time, upon written request, and that my Primary Care Physician may also request copies of my client files. I understand that there may be a fee for printing these files or for recording them to a disc or zip drive.*

_____ *I understand that I may opt into a case-study consisting of 10 or more sessions, which would include a re-evaluation of my wellbeing at the end of the study. My information will be kept HIPAA compliant in the documented study, which will be submitted as a mandatory project for my therapist's educational program. If I opt-in, I know that I have the right to a copy of my case study once complete. I understand that there may be a fee for printing these files or for recording them to a disc or zip drive.*

____ *Opt-In*

____*Opt-Out*

____*Ask Me After My First Visit*

_____ *I understand that my planned therapy is just that – therapy – and not sexual in nature. I agree not to sexually harass my therapist or their staff, and I understand that verbal abuse and sexual harassment of the staff and therapist will not be tolerated and will result in a call to security &/or local law enforcement, as well as being barred from scheduling future appointments.*

_____ *By signing this document, I have released my therapist and their staff from any liability – whether it be past, present, or future – related to treatment they provide or refuse to provide, including but not limited to: therapy, bodywork, and energy work.*

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Please finalize this document by completing the signature spaces below and returning the form to MoonwingMassage@Outlook.com no less than 2 business days prior to your appointment, or bring to your appointment at least 15 minutes prior to your scheduled start-time. If the client is under 18 years of age, please complete the Minor Liability Release Form below.

Signature: _____ ***Date:*** _____

Printed Name: _____ ***Initials:*** _____

Complete only if the client is under the age of 18 at the time of initial consultation or treatment:

MINOR LIABILITY RELEASE

By signing below, you are certifying that you are the parent or legal guardian of the minor receiving therapy treatment(s). You also understand that you will be required to remain at the facility and in the treatment room for the entirety of the minor's treatment(s), to supervise all interactions between the therapist and minor. You also agree that you have informed the therapist about all relevant medical history, symptoms, medications, and/or concerns associated with this minor.

PLEASE PRINT CLEARLY:

I _____*, certify that I am the parent or legal guardian of* _____*, who is* ____ *years of age. I understand the scope of therapy and that it is not meant to diagnose, treat, or cure any conditions and is not a replacement for standard medical care. I give permission for my minor child to receive treatment(s) at this facility and agree to all the above terms within the Intake form. I understand that I am to remain in the building during sessions, whether that is in the treatment room observing or in lounging areas.*

Signature: _____ ***Date:*** _____

Printed Name: _____ ***Initials:*** _____

OFFICE USE ONLY

Therapist to Review & Complete Prior to Initial Consultation/Treatment:

Reviewed By: _____ ***Expiration Date:*** _____

Consultation/Treatment Approved: ***Yes*** ***No*** ***Reschedule***

Contraindications Noted: _____

Recommended Wait for Treatment: _____

Referral to Other Professional: _____

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BIODYNAMIC CRANIOSACRAL THERAPY CASE STUDY SESSION LOG

SESSION	DATE	LENGTH	CLIENT SIGNATURE	STUDENT INITIAL
I				
II				
III				
IV				
V				
VI				
VII				
VIII				
IX				
X				