Intake Form

Name:____ Phone: _______________

Address:________________________ City:____________State:___ Zip Code:______

Email:____

YES **NO** May I use your email to contact you? I use this to connect with clients regarding Services, Fees, Policies, etc.

Emergency Contact: ____
Referred by: ____
YES **NO** May I contact this person to say 'Thanks' for the referral?

Health History

YES **NO** Have you experienced a CranioSacral Therapy session?

What brings you to CranioSacral Therapy? What are your goals?

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When did you first notice this? What brought it on?

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What have you tried to get relief? Did it help?

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____

YES **NO** Previous operations/surgery?

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YES **NO** Previous accidents/injuries?

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Do you have any other physical, mental or health conditions I should be made aware of? If so, please describe:

____
____

DISCLOSURE/CONSENT

Please thoroughly read the following paragraphs and then initial each paragraph after reading.

______ I understand that the CranioSacral therapist does not diagnose illness, disease or any other physical or mental disorder. In addition, the CranioSacral therapist does not prescribe medical treatment or pharmaceuticals. It has been made very clear to me that CranioSacral therapy provided includes techniques that are hands-on in nature and that my or my child's service will include hands-on touch techniques.

______ I understand that CranioSacral Therapy is considered to be a contraindication for recent injuries to the head and neck, ie.: recent whiplash, any recent fracture to the base of the neck, concussion, or hemorrhage and state that I am not currently experiencing any of these conditions.

______It has been made very clear to me that CranioSacral therapy is not a substitute for medical examinations and/or diagnosis and that it is recommended that I see a physician for any physical ailments that I might have.

______Because a CranioSacral therapist must be aware of existing physical conditions, I have stated all my known medical conditions above and take upon myself to keep the CranioSacral Therapist updated on my physical health. Further, I release Lindsay Christianson from responsibility and liability for any adverse reactions resulting from disclosed and undisclosed conditions.

I have completed the Health History information accurately and have read, understand and agree to the terms and conditions listed above in the Disclosure/Consent as well as acknowledge that I have received, read, understand and agree to the Complementary and Alternative Health Care Client Bill of Rights from Lindsay Christianson for CranioSacral Therapy.

x Client signature: ____ Date:____________

Complementary and Alternative Health Care Client Bill of Rights

Syzygy CranioSacral Therapy

Lindsay Christianson, BA (612) 208-3839 www.syzygyandalchemy.com
8441 Wayzata Blvd. Suite 125, Golden Valley, MN 54267

You have a right to the following information:

1) **Education & Training:**

- B.A. Metropolitan State University, Saint Paul, MN-2006
- Certified Holistic Health Coach, Institute for Integrative Nutrition, 2013-14
- Master Coach, Transformational Coaching Method, 2016-17
- 100-hour Dynamic Body Balancing (CranioSacral Therapy, Myofascial Release and Bio-field Therapy)-training with Dr. Carol Phillips, D.C., 2022

2) "THE STATE OF MINNESOTA HAS NOT ADOPTED ANY EDUCATIONAL AND TRAINING STANDARDS FOR UNLICENSED COMPLEMENTARY AND ALTERNATIVE HEALTHCARE PRACTITIONERS. THIS STATEMENT OF CREDENTIALS IS FOR INFORMATIONAL PURPOSES ONLY.

Under Minnesota law, an unlicensed complementary and alternative healthcare practitioner may not provide a medical diagnosis or recommend discontinuance of medically prescribed treatments. If a client desires a diagnosis from a licensed physician, chiropractor, or acupuncture practitioner, or services from a physician, chiropractor, nurse, osteopath, physical therapist, dietitian, nutritionist, acupuncture practitioner, athletic trainer, or any other type of healthcare provider, the client may seek such services at any time."

3) You may file any complaints with the facilitator via the email address listed above. As there is no advisory board for Dynamic Body Balancing, the Minnesota legislature enacted a law creating the Office of Unlicensed Complementary and Alternative Health Care Practice within the Minnesota Department of Health (MDH) to investigate complaints and take enforcement actions against CAP practitioners for violations of prohibited conduct. Complaints unresolved by contacting the facilitator via email should be filed with MDH, whose contact information is as follows: Office of Unlicensed Complimentary & Alternative Health Care Practice Health Occupations Program: MN Department of Health
PO Box 6475
St. Paul, MN 55164-0975
Phone (651)282-5623

4) The facilitator has no outstanding contracts with Medicare, Medical Assistance, or any private insurance companies, nor any health maintenance organizations, for the reimbursement of fees. The facilitator's fees, to be paid in full via immediately following rendering of services, are as follows:

Adult (13+, Not currently taking pregnant clients)	**Pediatric** (0-12 years old)

Initial Session (75 min) $135	Initial Session (45 min) $90
Standard Session (50 min) $100	Standard Session (25 min) $45
Jumpstart (Initial + 2 Standard) $300	Jumpstart (Initial + 2 Pediatric Standard) $150
Adult Punchcard (5 Standard) $450	Kids Punchcard (5 Pediatric Standard) $200

*PRICES DO NOT INCLUDE TAX. Packages are for individuals (not shared among family members) and non-transferable and non-refundable. Payments are due at the time of treatment unless other arrangements are made prior to treatment.

5) You have a right to reasonable notice of changes in services or charges.

6) Dynamic Body Balancing (DBB/CST) uses gentle pressure and traction in various areas of the body in order to stimulate movement. The facilitator will follow, support and sometimes exaggerate the client's movements to loosen restrictions in the fascia, which will help restore balance to the entire body, mind and spirit. Hands-off techniques may be used to work in the client's energetic biofield.

7) You have a right to complete and current information concerning the facilitator's assessment and recommended service that is to be provided, including the expected duration of the service to be provided.

8) You have the right to be treated with courtesy and respect, free from verbal, physical, or sexual abuse from the facilitator.

9) Client records and transactions with the facilitator are confidential, unless release of these records is authorized in writing by the client, or otherwise provided by law. You have the right to be allowed access to records and written information from records in accordance with Minnesota statutes sections 144.291 to 144.298.

10) Other services are available in the Twin Cities and surrounding area to which I may refer my clients. You have the right to choose freely among the available practitioners and to change practitioners or discontinue treatment after services have begun. You have the right to coordinated transfer when there will be a change in the provider of services.

11) In the event that the facilitator partners with other facilitators, you would have the right to choose freely among available facilitators and to change facilitators after services have begun, within the limits of health insurance, medical assistance, or other health programs. You have a right to coordinated transfer when there will be a change in the provider of services.

12) You may refuse services or treatment, unless otherwise provided by law.

13) You may assert your client rights without retaliation.

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