PEIRSMAN CRANIOSACRAL

NEW STUDENT FORM

We take privacy very seriously. Your personal information will never be shared.

Your Contact Information

Legal Name

Preferred Name

Date of Birth

Email

Phone

Address

Your Emergency Contact

Emergency Contact Name

Emergency Contact Phone

Relationship

Your CranioSacral Therapy (CST) Experience

What are your goals and intentions of taking this course? *(Please circle all that apply)*

Add CST to my practice	Self-Healing	Improved Immune Function
Relaxation/Stress Relief	Inner Exploration	Improved Mental Focus/Meditation
Improved Sleep	Emotional Release	Improved Mind/Body Awareness
Curiosity	Pain Relief	Expand Knowledge of Craniosacral Therapy
Other (please list):		Increased Ability to Give & Receive Healthy Touch

What tools, practices and activities do you use to relieve stress and maintain your wellbeing?

Are you a bodyworker or practice conventional or complementary of medicine? If so, what kind?

What is your profession?

Have you ever had a CranioSacral Therapy session? Yes No

What prompted you to attend classes in CranioSacral Therapy?

How did you find out about this class?

Where in your body do you hold tension?

Health Questionnaire

The following questions help us to address concerns and assess any conditions that might be contraindicative to your CranioSacral session and class. Please check all that apply and explain if necessary.

Do you have any of the following conditions? *(Circle all that apply)*

Open Scrapes, Cuts or Wounds   Contagious Disease   Contagious Skin Condition

Are you pregnant?   Yes   No

If you are pregnant, when is your expected due date?   (MM, YYYY)

Have you experienced any of these conditions? *(Circle all that apply)*

Asthma	Headaches/Migraines	ADHD	Tinnitus
Acid Reflux (GERD)	Recurrent Ear Infections	Autism	Allergies
Fibromyalgia	Recurrent Sinus Infections	Anxiety	Chronic Pain
PMS	Immune Disorders	Panic Attacks	Whiplash
TMJ	Genetic Diseases	Depression	Sleep Issues
Concussion	Post-Concussion Syndrome	Seizures	PTS

Other *(Please explain)*

How was your own birth? *(Circle all that apply and explain if necessary)*

Vaginal	Natural (No pain medications)	Long Labor	Hospital
C-Section	Epidural	Quick Labor	Home

Other *(please explain)*

Allergies/sensitivity to oils or scents:

Surgeries and/or Injuries *(please include approximate dates)*:

Accidents, Traumas and/or Abuse you have experienced *(please include approximate dates)*:

Emotional Abuse	Mental Abuse	Physical Abuse	Sexual Assault or Abuse
Accidents		Death(s) of loved ones	

Medications you are currently taking and the conditions they are related to:

Other health concerns, mental/medical conditions and phobias that you have:

Release of Liability

I understand that PCA teaches CranioSacral Therapy and that its' students are not licensed professionals. I understand that the CranioSacral Therapy I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during my session, I will immediately inform the therapist/student so that the pressure may be adjusted to my level of comfort. I further understand that CranioSacral Therapy should not be construed as a substitute for medical examination, diagnosis or treatment and that I should see a qualified medical specialist for any mental or physical ailment that I am aware of. I understand that CranioSacral therapists/students 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 CranioSacral Therapy 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 therapist/student/PCA updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's/student's/PCA's part should I fail to do so.

I agree to give 48-Hour notice if I choose to reschedule or cancel an appointment or class for any reason other than a family emergency or sudden illness. If I cancel without 48-hour notice or do not show up to my appointment or class I agree to pay the full cost of the craniosacral therapy session.

I affirm the accuracy of the information I have provided and understand and agree to the policies above.

Non-Compete Clause

I agree that I will not teach techniques learned at Peirsman CranioSacral courses within a 100 mile radius of:

- 30 Pine Haven Road, Tijeras, NM 87509

Print Name ____ Date________________

Signature ____ Date________________