doctor FOR moms | perinatal & pediatric natural health center

BCST Client Patient Information

Name:_____ Today's Date_____

Address (include postal code): _____

Daytime Phone: _____ Evening Phone: _____

Date of Birth: _____ Occupation: _____

E-mail Address: _____

- Please note that we are asking for your email address as a way to email you receipts, appointment reminders, or if we need to reach you for a specific/urgent reason. If you would like to be added to our newsletter mailing list please check here _____

Referral Source: _____ Marital Status: _____

Present Symptoms: What is the major condition you want to improve?

_____

_____

When did you first notice this condition? _____

What brought it on? _____

What activities aggravate the condition? _____

Is this condition getting progressively worse? ☐ No ☐ Yes

Please explain _____

Does this condition interfere with work? ☐ No ☐ Yes

With sleep? ☐ No ☐ Yes With daily routine? ☐ No ☐ Yes

Please explain _____

What have you done to get relief? _____

Has there been a medical diagnosis? ☐ No ☐ Yes

If so, by whom? _____

Please explain _____

Are you now under medical/therapeutic treatment for this condition? ☐ No ☐ Yes

List any medications (including aspirin) and nutritional supplements you are taking:

_____

_____

Please list (date and description) any accidents or operations: _____

_____

_____

_____

What are your intentions for this treatment? _____

_____

Describe the exercise activities you do (include frequency): _____

_____

Describe your diet: _____

_____

_____

List other therapies you receive:_____

_____

Which therapies work best for you? _____

List any body work in which you have participated; as a client or practitioner , i.e., yoga, massage therapy, reiki, touch therapy, chiropractic, physio, body talk , etc.

_____

_____

Do you know the details of your birth? _____

If you have children, when were your children born and any pertinent details of your birthing experience{s}? IE c-section , long labour. Etc:

_____

_____

Dental History – Braces, extractions, grinding , etc: _____

_____

Please list any additional comments regarding your health and well-being:

_____

_____

Informed Consent

I, _____, (client) understand that the biodynamic craniosacral therapy provided by Tanya Pawlick is intended to reduce pain, integrate structural imbalances, decrease myofascial restrictions, decrease neural impingement, increase range of motion, improve circulation, enhance relaxation, increase the experience of overall health and offer a positive experience of touch.

The general benefits of biodynamic craniosacral therapy, possible contraindications and the treatment procedure have been explained to me. I understand that biodynamic craniosacral therapy is not a substitute for medical treatment or medications, and that it is recommended that I work concurrently with my Primary Caregiver for any condition I may have. I am aware that the therapist does not diagnose illness or disease and does not prescribe medications.

I have informed the therapist of all my known physical conditions, medical conditions and medications, and I will keep the therapist updated on any changes.

Cancellation Policy

Please give at least 24 hours notice if you must cancel or reschedule your appointment. This gives the people on my waiting list the opportunity to receive treatment. It will also help you to avoid a $100 charge for any missed appointment, as that time was put aside just for you. I am happy to reschedule you if the need arises and look forward to helping you to the best of my ability.

I have read a copy of the therapist's policies. I understand them and agree to abide by them.

Client Signature Date