**Jan Lafleur, MA, CST, RYT, CHC**
Aurora, CO
findahappybalance.com
findahappybalance@gmail.com
303-306-8757

Name________________________________________________________________

Address______________________________________________________________

City/State _____________________________________ Zip code______________________

Day Phone __________________________ Cell Phone_______________________________

Email Address_________________________________________________________

Profession__________________________________ Birth Date______________________

Physician____________________________________ Phone Number: _______________

Referred by____________________________________________________________

Emergency contact: _____________________________________________________

**I UNDERSTAND THAT I AM RESPONSIBLE FOR $25 PAYMENT IF I DO NOT PROVIDE A 24 HOUR NOTICE OF APPOINTMENT CANCELLATION. INITIALS: _________**

**PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR HEALTH HISTORY:**

Reason for visit: ______________________________________________________________

Medications: _________________________________________________________________

| | | |
|---|---|---|
| Have you ever received CranioSacral Therapy? | YES | NO |
| Have you had any physiological cranial conditions, such as a stroke, intercranial hemorrhage or aneurysm, recent concussion or skull fracture, spinal tap, or Arnold Chiari? | YES | NO |
| Have you had surgery in the last 18 months? | YES | NO |
| Do you have chronic back pain or spinal conditions? | YES | NO |
| Do you have arthritis? | YES | NO |
| Do you have a heart condition? | YES | NO |
| Do you have high blood pressure? | YES | NO |
| Do you have frequent headaches or TMJ pain? | YES | NO |
| Have you had any injury in the last 18 months? | YES | NO |

Do you have <u>any other condition</u> I should be aware of? YES NO

**OTHER CONDITIONS, or EXPLAIN ANY OF ABOVE**:_____________________________________________

______________________________________________________________________________

**PLEASE DESCRIBE YOUR SELF-CARE PRACTICES:**

Nutrition & eating habits: ______________________________________________________________

______________________________________________________________________________

Body/mind practices, meditation, contemplative prayer, etc: _________________________________

Type & frequency of regular physical activity to maintain balance, strength, mobility & flexibility:

______________________________________________________________________________

Restorative / relaxation practices: _______________________________________________________

Level of satisfaction in personal or professional life: ______________________________________

## Informed Consent for Therapy

I, (print name) ___________________________________, request and consent to CranioSacral Therapy, which involves light manual touch. I understand that these sessions may include components of other related modalities such as Healing Touch, Reiki, and SomatoEmotional Release. I also understand that these services are complementary wellness modalities from which numerous benefits are possible and may vary according to each individual's condition, situation, and response patterns and that the particular outcomes of these sessions cannot be predicted with certainty nor can any guarantee be made regarding any particular result or outcome. I understand that healing is a process, so a series of sessions is recommended for improvement of symptoms.

I further acknowledge that these complementary therapies are not to be construed as substitutes for appropriate medical, psychiatric, or psychotherapeutic treatment and specifically exclude medical diagnosis or any procedure or therapy requiring health professional state licensure, certification, or registration to practice any branch of medicine in the State of Colorado.

I take full responsibility for my self-care and for discussing complementary care therapies and recommendations with my licensed medical provider.

My signature below signifies understanding, agreement, and acknowledgement of receipt of the above statement pursuant to the Colorado Natural Health Consumer Protection Act (2013).

______________________________________________________________________________

Signature Date

**Jan Lafleur, MA, RYT, CST, CHC.** Education and Training: Upledger Institute (FL), CranioSacral Therapy; Healing Beyond Borders, YogaLife Institute (PA, NH); Institute for Integrative Nutrition (NY); M.A., B. A. University of California; A.S, NH Technical Institute.

***For optimum experience, please wear comfortable, nonrestrictive clothing (leggings, sweats, t-shirt). Please <u>NO</u> perfume, belts, zippers, buttons, collars, or jewelry.**