

Starlight Therapeutics ★★ *Craniosacral, Reiki, and Massage Therapy*

1390 Oak St Suite 2, Eugene, OR 97401

Adult Intake Form

Name: _____

Pronouns: _____ Birth Date: _____

Address: _____

City: _____ State: ____ Zip: _____ Phone: _____

Email Address: _____

Referred by: _____ Occupation: _____

In case of emergency: _____ Phone: _____

For today's session, do you prefer Craniosacral or Reiki?

Do you want massage therapy to be included in your session?

What is your goal for today's session?

Are you pregnant? If yes, how far along?

Please list any mental health challenges, surgeries, and/or significant injuries, including at birth (with approximate dates):

What else, if anything, would you like to have written down here for my consideration?

Thank you for choosing Starlight Therapeutics!

Please continue this intake form on the other side of the page. ➔ ➔

Medical History

Please check any past or present conditions that apply to you:

- | | | |
|--|--|--|
| ☐ chronic pain | ☐ whiplash | ☐ osteoporosis |
| ☐ varicose veins | ☐ heart problems | ☐ skin rash / sensitivity |
| ☐ fever today | ☐ cancer | ☐ scoliosis |
| ☐ high blood pressure | ☐ stiff neck | ☐ fibromyalgia |
| ☐ blood clot | ☐ herniated or | ☐ seizures |
| ☐ insomnia | degenerated discs | ☐ arthritis |
| ☐ headaches | ☐ TMJ dysfunction | ☐ diabetes |
| ☐ easy bruising | ☐ fused vertebrae | ☐ HIV |
| ☐ allergies | ☐ edema | ☐ carpal tunnel synd. |

other: _____

Consent to Treatment, Financial Responsibility, and Release of Liability

1. I understand that this therapy is a non-invasive, complementary therapy intended to promote relaxation, reduce stress, and support the body's natural healing processes. It is not a substitute for medical care; results vary, and no specific outcome or cure is guaranteed.
2. I agree to fully and accurately disclose relevant physical and mental health information and promptly inform Anna Miller of any changes. I will communicate any discomfort, pain, or concerns during a session so the treatment can be adjusted.
3. To the fullest extent permitted by law, I knowingly and voluntarily release Anna Miller from claims or liability arising from or related to this therapy.
4. I will provide at least 24 hours' notice when cancelling or rescheduling, except in the event of sudden illness or a family emergency. Otherwise, I may be charged 60% of the applicable time-of-service fee.
5. I authorize Anna Miller to submit insurance claims and necessary treatment information, and to receive payment on my behalf. I remain responsible for any balance not paid by insurance, whether or not insurance is billed.

By signing below, I affirm that I have read, understand, and voluntarily agree to the terms of this intake form. I understand the nature and potential risks and benefits of craniosacral therapy and consent to treatment.

Signature: _____ **Date:** _____

If applicable:

Health Insurance Organization: _____

ID Number: _____ Group Number: _____