Awakening Wellness, LLC

Date of first visit: _____

Child's Name: _____

Parent/Guardian Name: _____

Address: _____

Home Number: _____ Cell Number: _____

E-mail address: _____

DOB: _____

Age: _____

General Health History:

List in order of **Most** important to **Least** important areas concern about your child.

1.

2.

3.

Have you seen a general practitioner or specialist for any of these problems? Yes / No

_____

Was there any treatment or diagnosis given? Yes / No

_____

Has the condition changed with treatment?

_____

Awakening Wellness, LLC

Pediatric Consent for Treatment

I _____ understand that I am responsible for payment if I cancel with less than 24 hours notice.

I, _____ as Parent or Guardian of _____, request and consent that Hilary Bilkis treat my child with CranioSacral Therapy. I understand that these sessions may include components of other related modalities such as, but not limited to SomatoEmotional Release, Reiki and Visceral Mobility.

The purpose of these sessions is to release physical and energetic restrictions in the body that may be impairing the functioning of all body systems, causing pain, illness or stress.

I understand that CranioSacral Therapy requires physical contact with my child's body.

I understand that the particular therapeutic outcomes of these treatments can not be predicted with certainty and no guarantee can be made regarding any particular result or outcome.

I understand that a series of sessions is recommended for optimal results.

This is not a substitute for medical or psychiatric treatment or psychotherapy.

I certify that all medical and social information on the intake form is correct to the best of my knowledge.

Please Date and Sign: _____