Consent form for Craniosacral Therapy treatment

I hereby request and consent to the service of Craniosacral therapy which falls under the heading of massage therapy treatment and other massage procedures, including various modes of remedial exercise, stretching, cupping, gua-sha, thermotherapy, and hydrotherapy, to be performed on me by a licensed massage therapist (LMT).

I understand that I will have an opportunity to discuss with the licensed massage therapist or with other clinic personnel the nature of Craniosacral therapy treatment and other procedures. I understand that 4-6 sessions are needed to assess whether the CST is a good choice for the complaint and produces changes for the patient.

I am informed that, as in all health care, in the practice of Craniosacral therapy there may be very slight risks to treatment, including, but not limited to, muscle strains and ligamentous sprains, bruising, light-headedness/dizziness, tenderness, or even an exacerbation of the chief complaint or symptoms for 24-28 hours.

I do not expect the massage therapist doing craniosacral therapy to be able to anticipate and explain all risks and complications of the work. I wish to rely on the massage therapist to exercise their good judgment during the course of the treatment which they feel at the time, based upon the facts that are known, to be in my best interests.

I am aware that there are many other healthcare alternatives offered by many other clinicians such as chiropractic, acupuncture, physiotherapy, massage, and many kinds of bodywork, etc.

I have read the above consent. I have also had an opportunity to ask questions about this consent, and by signing below, I agree to the above named procedures. I intend this consent form to cover the entire course of the treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ _____ _____

Printed Name, Signature, Date

WITNESS:

_____ _____ _____

Printed Name, Signature, Date