

Jackie Emm, MPH, RCST®
Biodynamic Craniosacral Therapy
199 Spotnap Road, Ste. 6A
Charlottesville, VA 22911
(434) 953-7214

Contact Information

Infant/Baby's Name: _____ Date: _____

Parent/Guardian Name: _____

Address: _____

Child DOB: _____ Age: _____ Referred by: _____

Best Phone #: _____ Email: _____

Reason here: _____

Does he/she have siblings? Ages? _____

Does he/she go to daycare or have a nanny? _____

Full time/part time? _____

Do the parent(s)/guardians work full time? _____

Has he/she had craniosacral therapy before? _____

Other bodywork/alternative therapies _____

History

Describe his/her birth experience - location, length of time, interventions if there were any, support for mom and baby etc...

Describe the prenatal period and whether the pregnancy was intentional (were you sick, healthy, happy, stressed etc...)

Please tell me about any concerns you have regarding your baby - digestive issues, colic, nursing issues, energy level, suspected food sensitivities, etc...

Do you feel like you have support in your parenting? Do you have any concerns around parenting at this time?

Consent I have willingly brought my/this child for a bodywork session, and give my consent for Jackie Emm, Registered Craniosacral Therapist, to perform a craniosacral therapy session with him/her. I certify that I have shared any relevant information with her so that she can make the best decision for the session/treatment. I also understand that she has training in other areas such as the vagus nerve system, and that she may use elements of this in her session. I realize this work is very gentle, but as in any body work, there may be some mild side effects such as a minor headache, body aches, or some emotional fluctuation due to shifting and releasing of trapped emotion in the body. I understand that if these side effects should arise, they should resolve within 1-3 days (with the normal treatment I would administer for these symptoms), and if they do not, I will let Jackie know. I understand that Jackie is not a psychotherapist/psychologist, but that she could make a referral for my/this child if we should want to seek that kind of treatment.

Parent/guardian signature: _____

Date: _____