



Sari Lewis, OTR/L, RCST®

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Scottsdale, AZ 85260

[www.sarihands.com](http://www.sarihands.com)

Phone: (480) 206-6592

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### Pediatric Health Information

Name of child: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Date: \_\_\_\_\_

Nicknames for child: \_\_\_\_\_

Address: \_\_\_\_\_ Phone # of parent: ( ) \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Parents Names: 1. \_\_\_\_\_ 2. \_\_\_\_\_

Cell Phone #1: ( ) \_\_\_\_\_ Cell Phone #2: ( ) \_\_\_\_\_

Email contact: \_\_\_\_\_

Referred by: \_\_\_\_\_

Primary Health Care Provider: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Permission to consult with primary provider? Please initial. Yes \_\_\_\_\_ No \_\_\_\_\_

Emergency Contact/relationship: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

### Birth History

Describe pregnancy: (duration, complications) \_\_\_\_\_

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Describe labor and delivery: (interventions~please include whether induced, use of forceps, vacuum, C-section, etc.) \_\_\_\_\_

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Describe personality, eating and sleeping patterns and any other pertinent information about your child:

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What results are you seeking for your child with Craniosacral Therapy treatments? \_\_\_\_\_

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List current medications:

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(Please continue to page 2)

**Significant Medical History (Include date and treatment received)**

Has your child been treated by any other practitioner for any of the symptoms listed? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Surgeries/Accidents/Injuries: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Any other information that you would like to share: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Financial Responsibility**

I agree to be financially responsible at the time of service for the full cost of sessions with Sari Lewis, OTR/L, RCST®. Sari Lewis, OTR/L, RCST® will not bill any insurance company for the services provided.

I realize that Wellness visits are separate from Occupational or Physical Therapy services. If my child is under care in another therapy program, I will inform Sari Lewis, OTR/L, RCST®.

\_\_\_\_\_  
**Parent/Guardian Signature** **Date**

I give my consent for Sari Lewis, OTR/L, RCST® to treat my minor child.

I agree to hold Sari Lewis, OTR/L, RCST® harmless from any claims, demands, injuries, damages or actions resulting from participation in a Craniosacral Therapy Program with Sari Lewis OTR/L, RCST®.

\_\_\_\_\_  
**Parent/Guardian Signature** **Date**

