Soni Radiance

Polarity/Cranial Sacral Therapy - Initial Intake Form

Name:_____ Date: _____

Date of Birth:_____ Occupation: _____

Address:_____

City:_____Zip:_____

Home:_____Work:_____Cell:_____

Email:_____

Emergency Contact Name and Number:_____

Primary reason for the appointment:

_____

_____

Current Stressors (Physical or Emotional):

_____

_____

___ Yes ___ No Do you wear contact lenses?

___ Yes ___ No Do you wear dentures?

___ Yes ___ No Do you have a pacemaker, internal pins, artificial joints, or other special equipment?

___ Yes ___ No Have you had a car accident (at any time), serious fall, or injury?

_____

___ Yes ___ No Do you have allergies? If so, please describe:

_____

_____

___ Yes ___ No Do you have arthritis? If so, please describe:

_____

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___ Yes ___ No Do you have any heart problems? If so, please describe:

_____

___ Yes ___ No Do you have any spinal problems? If so, please describe:

_____

___ Yes ___ No Are you presently pregnant? How far along? Complications?

_____

___ Yes ___ No Have you had surgery? How recently? Complications?

_____

___ Yes ___ No Do you take any prescribed medications please list:

_____

___ Yes ___ No Do you exercise or play sports on a regular basis? Please describe:

_____

___ Yes ___ No Are you receiving any other complementary care currently, (chiropractor, naturopathic, acupuncture, nutritional, herbal, homeopathic, hypnotherapy)? If so, please describe:

_____

___ Yes ___ No Do you have any other physical or mental condition of which I should be aware? If yes, please describe:

_____

All information is confidential. No information about any client will be discussed or shared with any third party without written consent of the client or parent/guardian if the client is under 18.

I verify that the above information is true and accurate to the best of my knowledge.

Signature of Client: _____ Date:_____

Signature of Parent or Guardian: _____Date:_____
(If client is under the age of 18)

Soni Radiance - Client Consent Form

I _____ herby consent to and authorize Dipti Soni to provide energy work (polarity, cranial unwinding, reiki, therapeutic touch, reflexology, chakra balancing). I understand that these energy bodywork techniques may range from gentle on-body and off-body to pressure point stimulation. I understand that with these therapies what I am going to experience is an energy-based form of holistic healing which utilizes bodywork, verbal counseling, exercise, and diet. These sessions may also include consultation and dialogue.

This is a holistic compliment to western medicine, and it does not take the place of medical care. It is not a substitute for a medical diagnosis or the services of a physician or other licensed health care provider. I invite you to discuss any recommendations with your primary care physician, obstetrician, gynecologist, oncologist, cardiologist, pediatrician, or other board-certified physician. At Soni Radiance, Dipti Soni will not advise that anyone discontinue a course of care or prescription drug that was prescribed by a licensed health-care professional. The FDA has not evaluated the herbal supplements that may be recommended, and herbal supplements are not intended to diagnose, treat, cure, or prevent any disease. I understand that the body has the ability to heal itself and I acknowledge that my health is my responsibility.

The possible effects may include: tingling or burning sensations as blood circulation increases, muscle soreness, nausea, release of some painful memories (emotional traumas are often stored in the body as tension), release of toxins stored in the body tissues (recommended to drink plenty of fluids after a session to assist in your body's natural healing process).

I state that I am over the age of 18. Further, I state that I understand and agree with the above statements and do not, and will not, hold Dipti Soni responsible for any liability. I understand that Dipti Soni is not a medical doctor, or doctor of Osteopathy.

Client signature:_____ Date:_____

If client is under the age of 18 (a minor) a parent or guardian must sign for consent to treat the client.

Minors Name:_____ Date:_____

Parent/Guardian Name:_____

Relationship to client:_____Signature:_____

Soni Radiance - Missed Appointment, Cancellation, & Refund Policy

Soni Radiance understands that your time is valuable, and the time set aside for your appointment is fundamental in your healing process. To respect your time and the time of other patients **there is a requirement of a 48-hour advanced notice of cancellation or change in appointment**. Soni Radiance understands that things can come up last minute but, **last-minute cancellations and no shows WILL BE subjected to a $50 fee.**

I understand that if I am unable to keep a scheduled appointment and need to cancel, I must give 48-hours advanced notice. If less than a 48-hour advanced notice is given I understand I will be charged a $50 fee. Please initial: _____

I understand that if I fail to show up to my scheduled appointment and no attempt to call and cancel or reschedule is made then the appointment is considered a "no call, no show" and I will be charged a $50 fee. Please initial: _____

I understand there are no refunds or returns on fees associated with appointments, packages, or products (herbal supplements, herbal oils, chakra stones, etc.).

Please initial: _____

To provide advanced notice about a cancellation please call at (602) 456 0849 or email at soniradiance@gmail.com

I agree to the above statements.

Client signature:_____ Date:_____

If client is under the age of 18 (a minor) a parent or guardian must sign for consent to treat the client.

Minors Name:_____ Date:_____

Parent/Guardian Name:_____

Relationship to client:_____Signature:_____