Physician Consent Form

I give my consent for _____ to receive therapeutic massage and bodywork, as well as CranioSacral therapy. I confirm that there are no contraindications against the following (please initial):

__ Slight changes in intracranial and/or intraspinal pressure

__ Improvement in the flow of blood, cerebrospinal fluid, and lymph

__ Gentle traction of the occiput and sacrum

__ Gentle traction of the bones of the face

_____ _____

Signature Date

_____

Print Name

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