# CranioWorks

**Mary Quintero, LMT**

I have made the decision to receive Craniosacral Therapy and/or massage therapy. I understand that Craniosacral Therapy and massage therapy are for the benefit of my body and mind. This includes a variety of therapies, including stress reduction, relief from muscular tension, spasm or pain or for increasing circulation or energy flow. I agree to communicate with my therapist any time that I feel my well being is in jeopardy.

I, further, understand that massage therapists do not diagnose illness, disease, or any physical or mental condition, nor do they prescribe medical treatment, medications, or perform spinal thrust manipulations. I understand that Craniosacral Therapy and massage therapy are not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for such services.

Additionally, I realize that the particular therapeutic outcomes of these treatments, individually and jointly, cannot be predicted with certainty and no guarantee is made regarding any particular result or outcome.

I have disclosed all known medical conditions and will continue to update the massage therapist of any changes in my health.

Signature: _____ Date:_____