



# Professional Training in Craniosacral Therapy

## Application Form

- ❖ Please type or print your answers clearly
- ❖ Please email a copy to Brendan Pittwood and to Terry Collinson - [tutors@stillnesstrainings.com](mailto:tutors@stillnesstrainings.com)
- ❖ **Please post a hard copy to Australia, with your passport-style photograph: 27 Olive Avenue, Phegans Bay, NSW 2256**, marked "attention Terry Collinson".
- ❖ A reference letter is also required from two people who are familiar with you and your work. Please include these with your application.

***Any information that you provide is given on a voluntary basis and is held in the strictest confidence. None of the information, except for name, address, telephone number and email address is held on a computer database.***

Name: \_\_\_\_\_

Recent Photograph:

Address: \_\_\_\_\_

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

Contact Phone: \_\_\_\_\_

Is this a home or work number? \_\_\_\_\_

Mobile: \_\_\_\_\_

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

Profession: \_\_\_\_\_

Age: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Male/Female (please circle one)

Family and Relationships details:(married or partnered, divorced, widowed, single, children)

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

### Education and Training

Degree/Diploma/Certificate	Length of Training yrs, months or hrs	Completion Date

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**Name:** \_\_\_\_\_

**Professional Qualifications:** (Association Membership, Register of Practitioners, etc.)

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**Description of professional practice:**

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**Where is your practice location?** \_\_\_\_\_

**Approximate number of clients per week:** \_\_\_\_\_ **Number of years in practice:** \_\_\_\_\_

**Previous Craniosacral Therapy Training:**

<b>Courses Taken, Organisation, Teacher</b>	<b>Length of Training yrs, months or hrs</b>	<b>Date</b>

**Details of any other professional training or training development:**

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**Name:** \_\_\_\_\_

## **Training in Anatomy and Physiology:**

<b>Training Provider</b>	<b>Length of Training yrs, months or hrs</b>	<b>Date</b>

**Please give a brief outline of the areas covered within the training:**

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## **Training in Pathology:**

<b>Training Provider</b>	<b>Length of Training yrs, months or hrs</b>	<b>Date</b>

**Please give a brief outline of the topics studied:**

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If you have not had any professional form of training in Anatomy and Physiology or Pathology, have you acquired knowledge of these subjects through other means, such as home study, study groups or distance learning?

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If you have no previous training in Anatomy and Physiology, you will need to follow an **approved program of study**. This should be completed prior to the commencement of the training however special consideration may be offered and students are invited to apply to undertake these studies concurrently.

If you have entered or intend to enter such a program please complete the following:

**Contact hours:** \_\_\_\_ **Date commenced:** \_\_/\_\_/\_\_ **Completion date:** \_\_/\_\_/\_\_

**Training provider:** \_\_\_\_\_

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**Name:** \_\_\_\_\_

### **Health Profile**

By participating in the training each participant will be both practising on other students and will themselves be receiving the work from other participants. While the work is therapeutic in its nature, it can bring to the surface issues that the student is working to resolve in himself or herself, both subconsciously and consciously. It is therefore mandatory for students to support their own healing, outside of the training, with professional therapy sessions, preferably craniosacral therapy.

It has been the experience of the tutors that the knowledge of important factors in a person's life has helped to form an appropriate measure of safety for the student. This safety allows the students to explore their process of healing within the framework of the course, and their ongoing development as practitioners.

We would therefore request that you be as truthful as possible about your history. We also respect your need for privacy and that you feel comfortable with anything that you might tell us. Once again the contents of this questionnaire are for our tutors only, and nothing is entered into any form of database or retrieval system.

### **Please describe your current state of health:**

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### **Illnesses or symptoms:**

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### **Current and past medication:**

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### **Do you have any problems with physical mobility or any challenges to your hearing or sight?**

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### **Do you have any learning difficulties, such as dyslexia or ADD?**

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**Name:** \_\_\_\_\_

**Do you have any special needs?** (eg do you need to sit closer to the front of the class or the teacher because of visual or hearing difficulties)

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### **Physical Medical history:**

Where possible state these in chronological order from birth to the present day. State whether you think any of these are still affecting your current well-being:

### **Physical illnesses:**

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### **Accidents, falls, traumatic events etc:**

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### **Surgical history:**

Hospitalisations, surgery, emergency care, fractures, wounds, major dental work or surgery (please include dates):

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### **Psycho-emotional medical history:**

History of events that may have deeply affected your emotional well-being

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**Name:** \_\_\_\_\_

**Does any of your psycho-emotional history affect the quality of your day-to-day life and if so, how?**

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**Please state if you have found support for your emotional / psychological well-being and if so what this is:**

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**Are there any psychiatric, psychological or emotional processes that affect your functioning or well-being and if so please describe?**

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## **Ongoing therapy:**

If you have recently or are currently in therapy, will you be informing your therapist of your possible entry into this training?

Yes  No

If you or your therapist wishes to have any further clarification about the training, please discuss this with us directly. I would like to discuss this with a tutor. Yes  No

Because of the nature of the teaching and for us to understand your needs and how best to support you it is strongly advisable for us to have your permission to contact your main therapist(s) directly. Yes  No

Please contact: \_\_\_\_\_

**PLEASE PRINT**

First Name

Surname

Telephone number: (    ) \_\_\_\_\_ Therapy \_\_\_\_\_

**Current therapy - allopathic or complementary** (that you are experiencing as a patient):

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**Name:** \_\_\_\_\_

**We ask that you nominate one referee who knows you professionally, and one who knows you personally and will be happy to speak on your behalf and write a reference, enclosed with this application.**

**Please name your referees below:**

**Professional Referee:** \_\_\_\_\_

**PLEASE PRINT**

First Name

Surname

Contact phone numbers:

Work ( ) \_\_\_\_\_ Home ( ) \_\_\_\_\_

Mobile \_\_\_\_\_

**Personal Referee:** \_\_\_\_\_

**PLEASE PRINT**

First Name

Surname

Contact phone numbers:

Work ( ) \_\_\_\_\_ Home ( ) \_\_\_\_\_

Mobile \_\_\_\_\_

## **Personal Responsibility**

The training course in Biodynamic Craniosacral Therapy is designed to provide insight and direct experience of this therapeutic approach. However, the course is not intended to be, nor may it be assumed to be, a treatment or cure for any existing complaint or illness, or for any complaint or illness that arises during the training period. It is a requirement during the training, and your personal responsibility, to secure a program of therapy for your own personal well being, which is independent of the training program.

**Signed** \_\_\_\_\_ **Date** \_\_\_ / \_\_\_ / \_\_\_

**Please print your name here:** \_\_\_\_\_

Thank you for completing the Application Form. If there are parts of the form that you find difficult to answer or you would like some help or guidance then please feel free to call Daya in Sydney on 0448 250 445 or email Daya at: [stillnesstrainings@gmail.com](mailto:stillnesstrainings@gmail.com) or Terry and Brendan at [tutors@stillnesstrainings.com](mailto:tutors@stillnesstrainings.com)

**Any other information:** please attach extra sheets as necessary

***It is understood that all of your information is given on a voluntary basis and is held in strictest confidence.***

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