Autumn Woodward, MA, LMBT

Pediatric Client Intake Form

Child's Name _____ Birth date _____ Age _____

Parent(s) Name(s) _____ Home Phone _____

Work Phone _____ Cell Phone _____

Street _____ City_____ State _____ Zip _____

Parent Occupation _____

How did you hear about me? ❑ Friend/Family ❑ Yelp ❑ Google Search ❑ Newspaper ❑ Health Professional
Name of person who referred you_____

Please mark your goals for your child's Pediatric Massage Program: Please note that massage has been found to be helpful in the areas below for some children, but the response of each child to massage therapy will vary. In the first 2-3 sessions we will determine whether my work seems of benefit to your particular little one.

- ☐ Provide comfort
- ☐ Reduce stress
- ☐ Reduce pain
- ☐ Ease depression
- ☐ Decrease anxiety
- ☐ Reduce muscle hypertonicity (tension)
- ☐ Improve muscle tone (decrease hypotonicity)
- ☐ Improve gastrointestinal functioning
- ☐ Improve joint mobility / range of motion
- ☐ Promote orientation of extremities toward midline
- ☐ Reduce chronic fatigue
- ☐ Improve pulmonary functions
- ☐ Reduce lethargy
- ☐ Reduce colic / chronic abdominal pain
- ☐ Promote growth for baby born prematurely/child
- ☐ Improve self-soothing behavior
- ☐ Improve attentiveness and responsiveness
- ☐ Improve sleep patterns
- ☐ Decrease hypersensitivity to touch
- ☐ Encourage vocalization
- ☐ Enhance child's body awareness
- ☐ Promote parent-child bonding

Other Goals: _____

Health History

Birth History: Weeks gestation: _____ ☐ Premature Delivery: ☐ Vaginal ☐ C-Section

Birth or Postpartum complications? ☐ No ☐ Yes (describe):

Is your child currently under the care of a primary healthcare provider? ☐ Yes ☐ No

Name of healthcare provider: _____

Name of healthcare facility: _____

Location: _____ Phone: _____

May I exchange information when necessary with this provider? ☐ Yes ☐ No

How is your child's health in general?_____

Child's Health History (continued)

Please mark any of the following that your child now has or has had in the past. Identify the condition and location where applicable.

Now	Past	Condition	Now	Past	Condition
☐	☐	**Skin Conditions** (includes rashes, topical allergies, fungal infections, etc.) Type _____ Location _____	☐	☐	**Respiratory Conditions** (includes sinus, lung and bronchial conditions, etc.) Type _____ Location _____
☐	☐	**Muscle Conditions** (includes strains, tendonitis, spasms, cramps, etc.) Type _____ Location _____	☐	☐	**Circulatory Conditions** (includes heart, blood pressure, arteries and venous conditions, etc.) Type _____ Location _____
☐	☐	**Joint Conditions** (includes sprain, arthritis, degenerating joints, etc.) Type _____ Location _____	☐	☐	**Reproductive Conditions** (includes pregnancy, prostate, menstruation, etc.) Type _____ Location _____
☐	☐	**Nervous System Conditions** (includes numbness, tingling, nerve damage, shingles, etc.) Type _____ Location _____	☐	☐	**Digestive Conditions** (includes constipation, diarrhea, ulcers, etc.) Type _____ Location _____
☐	☐	**Surgery** Date: Reason: Location: Description:	☐	☐	**Cancer** Type_____ Location_____ Treatment:
☐	☐	**Headaches** Frequency_____	☐	☐	**Infectious or Communicable Conditions** Type _____ Location _____
☐	☐	**Emotional Conditions** Describe:	☐	☐	**Other Conditions** (includes any other health condition not previously listed) Type _____ Location_____ _____

☐ ☐ **Autism/Spectrum**
Describe:

☐ ☐ **Cerebral Palsy**
Symptoms:

Other medical conditions, symptoms and/or further explanations: _____

_____

Is your child taking any medications? Please list_____

My child is sensitive/allergic to the following scents/oils/lotions:_____
or ❑ No known sensitivities

What hand does your child write with, if she or he is old enough?_____

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING TODAY?

❑Sunburn ❑ Inflammation ❑ Severe pain
❑ Headache ❑ Open cuts, bruises, burns ❑ Irritated skin rash
❑ Cold/flu ❑ Contagious condition ❑ Poison ivy/oak
❑ Fever ❑ Diarrhea or other sickness ❑ Infection
❑Recent immunization/vaccination (wait 48 – 72 hours)

Is there anything else you would like me to know?

When the child receives a massage, she/he will not be touched in any area that would usually be covered by a bathing suit, aside from the upper back (shorts for boys, two-piece bathing suits for girls). Is there any other area that your child does not want touched?_____

Consent for Child to Receive Massage

I understand that my child will be participating in pediatric massage therapy as a form of adjunct health care, and that massage is *not* a substitute for medical examination and treatment/care by my child's doctor, and that no diagnosis will be made. I have noted above all complications, risks, or conditions my child has experienced. I recognize the importance of updating the massage therapist on changes in my child's health.

I realize that massage will only be provided with the permission of my child in that moment. If my child does not wish to receive massage or be touched, her/his wish will always be honored, even if part-way through the session. If this is the case, the session time can be used for the parent to learn basic massage techniques, and connecting with the child to see if interest in receiving massage can be encouraged or regained. By my signature below, I give consent for my child to receive massage or bodywork. I understand that I (or child's other parent/guardian) need to remain in the treatment room for the massage session.

I understand I must give 24 hours notice to cancel any bodywork session to avoid being charged.

Signature:_____ Date:_____ Print Name:_____

Parent/Legal Guardian of_____

Practitioner's Contact Information:

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