

Pediatric Client Intake Form

Child's Name _____ Birthdate _____ Age _____

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

Work Phone _____ Cell Phone _____

Street _____ City _____ State _____ Zip _____

Parent Occupation/Employer _____

Please mark your goals for your child's Pediatric Massage Program:

- | | |
|--|---|
| <input type="checkbox"/> Provide Comfort | <input type="checkbox"/> Improve pulmonary functions |
| <input type="checkbox"/> Promote relaxation | <input type="checkbox"/> Decrease symptoms of atopic dermatitis |
| <input type="checkbox"/> Reduce stress | <input type="checkbox"/> Reduce lethargy |
| <input type="checkbox"/> Reduce pain | <input type="checkbox"/> Reduce colic / chronic abdominal pain |
| <input type="checkbox"/> Ease Depression | <input type="checkbox"/> Promote growth for baby born prematurely/child |
| <input type="checkbox"/> Decrease anxiety | <input type="checkbox"/> Improve self-soothing behavior |
| <input type="checkbox"/> Reduce muscle hyper tonicity | <input type="checkbox"/> Improve attentiveness and responsiveness |
| <input type="checkbox"/> Improve muscle tone (decrease hypo tonicity) | <input type="checkbox"/> Improve sleep patterns |
| <input type="checkbox"/> Improve gastrointestinal functioning | <input type="checkbox"/> Decrease hypersensitivity to touch |
| <input type="checkbox"/> Improve joint mobility / range of motion | <input type="checkbox"/> Encourage vocalization |
| <input type="checkbox"/> Promote orientation of extremities toward midline | <input type="checkbox"/> Enhance child's body awareness |
| <input type="checkbox"/> Reduce chronic fatigue | <input type="checkbox"/> Promote parent-child bonding |

Other Goals: _____

Health History

Birth History: Biological Child Adopted Foster Child

Weeks gestation: _____ Delivery: Vaginal Forceps C-Section Vacuum Extraction

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

My child is developing:

- like an average child for his/her age in all areas of development
- differently than an average child his/her age in any area of development.

Describe: _____

Please list medications, supplements or homeopathics the child is now taking:

Medication/Herb/Etc.	Reason	Started	Dosage
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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
<input type="checkbox"/>	<input type="checkbox"/>	Skin Conditions (includes rashes, topical allergies, fungal infections, etc.) Type _____ Location _____	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Conditions (includes sinus, lung and bronchial conditions, etc.) Type _____ Location _____
<input type="checkbox"/>	<input type="checkbox"/>	Muscle Conditions (includes strains, tendonitis, spasms, cramps, etc.) Type _____ Location _____	<input type="checkbox"/>	<input type="checkbox"/>	Circulatory Conditions (includes heart, blood pressure, arteries and venous conditions, etc.) Type _____ Location _____
<input type="checkbox"/>	<input type="checkbox"/>	Joint Conditions (includes sprain, arthritis, degenerating joints, etc.) Type _____ Location _____	<input type="checkbox"/>	<input type="checkbox"/>	Reproductive Conditions (includes pregnancy, prostate, menstruation, etc.) Type _____ Location _____
<input type="checkbox"/>	<input type="checkbox"/>	Nervous System Conditions (includes numbness, tingling, nerve damage, shingles, etc.) Type _____ Location _____	<input type="checkbox"/>	<input type="checkbox"/>	Digestive Conditions (includes constipation, diarrhea, ulcers, etc.) Type _____ Location _____
<input type="checkbox"/>	<input type="checkbox"/>	Infectious or Communicable Conditions Type _____ Location _____	<input type="checkbox"/>	<input type="checkbox"/>	Other Conditions (includes any other health condition not previously listed) Type _____ Location _____

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

Please list any recent accidents, illnesses or surgeries (past 2 years -- or those that are still affecting your child): _____

Please list any special dietary/nutritional considerations: (ie: *gluten-free diet, allergies*) _____

How do these symptoms affect the child's daily life? _____

Therapeutic History

Has your child ever received massage or another bodywork therapy (professionally or by a parent's touch)? (example: *yoga therapy, cranial sacral therapy, bioaquatic therapy*) Yes No

If yes, please explain: _____

Please list other complementary therapies or educational programs in which your child participates:

Therapy/Program	Reason	Started	Practitioner
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

May I exchange information when necessary with these providers? Yes No

Has your child been evaluated for or diagnosed with Sensory Integration Disorder? Yes No

If yes, please explain evaluation, diagnosis and/or therapy program: _____

How does your child respond to touch/movement? Does your child:

	Never	Some	Often	Always	In the past	This is a problem
dislike being held or cuddled?						
seem irritated when touched?						
bang or hit head on purpose?						
seem overly aware of touch, texture or temperature?						
have an increased response to pain?						
Lack awareness of being touched?						
bite, chew or suck on blanket/pacifier/something to calm?						
frequently bump into or push people or items?						
have a strong need to touch objects and people?						
try to bite people?						
dislike being bounced, rocked or swung?						
seek out rough-housing play?						
have fear in space (i.e. on stairs, heights, etc.)?						
dislike being off balance?						

Personal History

Please describe your child's communication style:

Verbal Word Approximations ASL PECs Augmentative Device Gestures None

Other: _____

How does your child deal with change? _____

What types of methods does your child use to manage stressful situations (self-soothing techniques)?

What makes your child:

(And, how do you deal with it)

Happy? _____

Sad? _____

Angry? _____

Stressed? _____

Excited? _____

Does your child attend school/preschool/daycare? Yes No

If yes, what are his/her teacher's name(s)? _____

What are the names/types of his/her pets? _____

What are the names of his/her siblings? _____

What are the names of his/her friends? _____

What types of exercise interests your child? _____

How does your child prefer to spend his/her time (hobbies/interests)? _____

I have listed all my child's known medical conditions and physical limitations and will inform the massage therapist in writing of any changes between bodywork sessions. I understand that a massage therapist must be aware of any and all existing physical conditions that I have in order to provide appropriate massage. I further understand that a massage therapist neither diagnoses nor prescribes for illness, disease, or any other medical, physical, or emotional disorder, nor performs any thrusting joint or spinal manipulations or adjustments. I am responsible for consulting a qualified primary care provider for any physical ailment that my child may have.

I agree I will give twenty-four (24) hours notice to cancel any bodywork session to avoid being charged.

Signed _____ Date _____

Parent/Legal Guardian of _____