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:

- ❑ Provide Comfort
- ❑ Promote relaxation
- ❑ Reduce stress
- ❑ Reduce pain
- ❑ Ease Depression
- ❑ Decrease anxiety
- ❑ Reduce muscle hyper tonicity
- ❑ Improve muscle tone (decrease hypo tonicity)
- ❑ Improve gastrointestinal functioning
- ❑ Improve joint mobility / range of motion
- ❑ Promote orientation of extremities toward midline
- ❑ Reduce chronic fatigue
- ❑ Improve pulmonary functions
- ❑ Decrease symptoms of atopic dermatitis
- ❑ 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: ❑ Biological Child ❑ Adopted ❑ Foster Child

Weeks gestation:_____ Delivery: ❑ Vaginal Forceps ❑ C−Section ❑ Vacuum Extraction

Postpardum 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 we 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
❑	❑	**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_____
❑	❑	**Infectious or Communicable Conditions** Type_____ Location_____	❑	❑	**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 we 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.

_____	_____	_____
Parent / Legal Guardian Signature	Print Name	Date / Time