****

**Pediatric Client Intake Form**

**Child’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent(s) Name(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Street \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent Occupation/Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please mark your goals for your child’s Pediatric Massage Program:**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Provide Comfort** |  | **Improve pulmonary functions** |
|  | **Promote relaxation** |  | **Decrease symptoms of atopic dermatitis** |
|  | **Reduce stress** |  | **Reduce lethargy** |
|  | **Reduce pain** |  | **Reduce colic / chronic abdominal pain** |
|  | **Ease Depression** |  | **Promote growth for baby born prematurely/child** |
|  | **Decrease anxiety** |  | **Improve self-soothing behavior** |
|  | **Reduce muscle hyper tonicity** |  | **Improve attentiveness and responsiveness** |
|  | **Improve muscle tone (decrease hypo tonicity)** |  | **Improve sleep patterns** |
|  | **Improve gastrointestinal functioning** |  | **Decrease hypersensitivity to touch** |
|  | **Improve joint mobility / range of motion** |  | **Encourage vocalization** |
|  | **Promote orientation of extremities toward midline** |  | **Enhance child’s body awareness** |
|  | **Reduce chronic fatigue** |  | **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 check 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)****Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Location \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |  | **Circulatory Conditions****(includes heart, blood pressure, arteries and venous conditions, etc.)****Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Location \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
|  |  | **Joint Conditions****(includes sprain, arthritis, degenerating joints)****Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Location \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |  | **Reproductive Conditions****(includes pregnancy, prostate, menstruation)****Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Location \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
|  |  | **Nervous System Conditions****(includes numbness, tingling, nerve damage, shingles, etc.)****Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Location \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |  | **Digestive Conditions****(includes constipation, diarrhea, ulcers)****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 you 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 my child has 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Bailey Savannah Dull, LMT #11479, CPMT, CTRS**

**Pediatric Massage of the Upstate**

**864-810-0067**

**bailey@pediatricmassageupstate.com**