

# Pediatric Client Intake Form

Child's Name \_\_\_\_\_ Birthdate \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_\_  
Parent(s) Name(s) \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_  
Work Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State WA Zip \_\_\_\_\_  
Parent Occupation/Employer \_\_\_\_\_

Please include me on your private mailing list to receive updated information and special offers  
If you prefer to receive information via email, list your email address: \_\_\_\_\_

## ◆ Program Goals

Please mark your goals for your child's Pediatric Bodywork 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 in premature infant     |
| <input type="checkbox"/> Decrease anxiety                                  | <input type="checkbox"/> Improve self-soothing behavior         |
| <input type="checkbox"/> Reduce muscle hypertonicity                       | <input type="checkbox"/> Improve attentiveness and responsivity |
| <input type="checkbox"/> Improve muscle tone (decrease hypotonicity)       | <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. <i>example: Vitamin C</i>	REASON <i>colds</i>	STARTED <i>10/2003</i>	DOSAGE <i>500 mg once/day</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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"/>	<b>Skin Conditions</b> (includes rashes, topical allergies, fungal infections, etc.) Type _____ Location _____	<input type="checkbox"/>	<input type="checkbox"/>	<b>Respiratory Conditions</b> (includes sinus, lung and bronchial conditions, etc.) Type _____ Location _____
<input type="checkbox"/>	<input type="checkbox"/>	<b>Muscle Conditions</b> (includes strains, tendinitis, spasms, cramps, etc.) Type _____ Location _____	<input type="checkbox"/>	<input type="checkbox"/>	<b>Circulatory Conditions</b> (includes heart, blood pressure, arteries and venous conditions, etc.) Type _____ Location _____
<input type="checkbox"/>	<input type="checkbox"/>	<b>Joint Conditions</b> (includes sprains, arthritis, degenerating joints, etc.) Type _____ Location _____	<input type="checkbox"/>	<input type="checkbox"/>	<b>Reproductive Conditions</b> (includes pregnancy, prostate, menstruation, etc.) Type _____ Location _____
<input type="checkbox"/>	<input type="checkbox"/>	<b>Nervous System Conditions</b> (includes numbness, tingling, nerve damage, shingles, etc.) Type _____ Location _____	<input type="checkbox"/>	<input type="checkbox"/>	<b>Digestive Conditions</b> (includes constipation, diarrhea, ulcers, etc.) Type _____ Location _____
<input type="checkbox"/>	<input type="checkbox"/>	<b>Infectious or Communicable Conditions</b> Type _____ Location _____	<input type="checkbox"/>	<input type="checkbox"/>	<b>Other Conditions</b> (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 <i>example: Speech Therapy</i>	REASON <i>Apraxia</i>	STARTED <i>10/2003</i>	PRACTITIONER <i>Joe Smith, SLP</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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?						
have little or delayed response to pain?						
lacks awareness of being touched?						
bites, chews or sucks 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 (e.g. on stairs, heights, etc.)?						
dislike being off balance?						

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## ◆ Personal History

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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)?  
(example: suck thumb, get back rub, take a bath)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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 \_\_\_\_\_