

New Pediatric Client Information

Child's Name _____ Birth Date _____ Today's Date _____

Family – Parents, Siblings, Creatures? _____

Parent(s)' Occupation _____ Employer _____

Address _____

City _____ State _____ Zip _____

Email Address _____ May I add you to my mailing list? _____

Best Phone to Contact _____ Alternative Contact # _____

How did you learn about me? _____

If it was a personal referral, may I thank them for their referral? _____

Has your child received Professional Bodywork before? Y _____ N _____

If Yes, What Kinds? _____

Please check any of the following that apply to your child now or previously:

- | | | |
|--|---|--|
| <input type="checkbox"/> Nursing Concerns | <input type="checkbox"/> Torticollis | <input type="checkbox"/> Hypo or Hyperglycemia |
| <input type="checkbox"/> Latch Issues | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Muscle Strain |
| <input type="checkbox"/> Poor Suck Reflex | <input type="checkbox"/> Ear tubes | <input type="checkbox"/> Joint Sprain |
| <input type="checkbox"/> Colic | <input type="checkbox"/> Teeth Grinding | <input type="checkbox"/> Notable Falls |
| <input type="checkbox"/> Reflux | <input type="checkbox"/> Jaw Clenching | <input type="checkbox"/> Headaches - Migraines |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Developmental Delay(s) | <input type="checkbox"/> Constipation/Irregularity |
| <input type="checkbox"/> Allergies (please list) | <input type="checkbox"/> Tight Frenulum | <input type="checkbox"/> Other Conditions |

Details for items checked above _____

Birth Story: _____

Is your child currently experiencing any cold, flu-like, or other symptoms of infection? _____

Has your child had any serious or chronic illness or traumatic accidents? _____

If yes, please give dates and details: _____

Please list and explain other conditions/symptoms your child is or has experienced:

In order to effectively provide lymphatic drainage therapy (LDT), please answer these questions:

Does your child have a history of cancer or radiation therapy? _____

If any surgery, were any lymph nodes removed? ____ Does your child have a history of lymphedema? ____

Is your child currently, or has she/he at any time within the last 12 months been under the care of a physician?
If yes, for what condition?

Is your child on any medication? _____ If yes, which ones, and what is each prescribed for?

If appropriate, and with your knowledge, may I have permission to contact your Doctor / Therapist? _____

Doctor / Therapist Name: _____ Telephone _____

Lifestyle

What forms of play or exercise does your child enjoy, and how often?

How much water does your child drink each day? _____

What is your child passionate about? _____

What goals do your child, or you, have for this session? _____

Is there anything else that I should know about your child to best provide craniosacral, lymphatic drainage, and bodywork sessions for your child?

I have completed this health form to the best of my knowledge. I understand that CranioSacral Therapy, Lymphatic Drainage Therapy, Massage Therapy, and Bodywork services are a therapeutic health aid. These therapies and services do not take the place of a physician's care when indicated.

Any information exchanged during a Bodywork session is confidential and is only used to provide you with the best health care services.

If I am not able to make a scheduled appointment, I agree to cancel the appointment with a *phone call* in advance, by at least 24 hours.

If I miss or cancel a scheduled appointment without giving 24 hours notice, I agree to pay the full appointment fee.

Parent's/guardian's signature required for a minor:

Signature _____ Date _____

Thank you for sharing this information. It is truly helpful.