Pediatric Client Intake Form

Marcus Walther, BCTMB, LMT
Pathways To Health, LLC
Reston, VA (757)753-4940

Child's Name _____ Birthdate___/___/_____ Age_____

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

Work Phone (_____)_____ Cell Phone (_____)_____

Street_____ City_____ State_____ 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:

- ☐ Provide comfort
- ☐ Reduce stress
- ☐ Ease depression
- ☐ Reduce muscle hypertonicity
- ☐ Improve gastrointenstinal functioning
- ☐ Promote orientation of extremities toward midline
- ☐ Improve pulmonary functions
- ☐ Reduce lethargy
- ☐ Promote growth in premature infant
- ☐ Improve attentiveness and responsivity
- ☐ Decrease hypersensitivity to touch
- ☐ Enhance child's body awareness
- ☐ Promote relaxation
- ☐ Reduce pain
- ☐ Decrease anxiety
- ☐ Improve muscle tone (decrease hypotonicity)
- ☐ Improve joint mobility / range of motion
- ☐ Reduce chronic fatigue
- ☐ Decrease symptoms of atopic dermatitis
- ☐ Reduce colic / chronic abdominal pain
- ☐ Improve self-soothing behavior
- ☐ Improve sleep patterns
- ☐ Encourage vocalization
- ☐ Promote parent-child bonding

OtherGoals:_____

◆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. *example: Vitamin C*	REASON *colds*	STARTED *10/2003*	DOSAGE *500 mg once/day*

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, tendinitis, spasms, cramps, etc.) Type _____ Location _____	❑	❑	**Circulatory Conditions** (includes heart, blood pressure, arteries and venous conditions, etc.) Type _____ Location _____
❑	❑	**Joint Conditions** (includes sprains, 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 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 *example: Speech Therapy*	REASON *Apraxia*	STARTED *10/2003*	PRACTITIONER *Joe Smith, SLP*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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?						

❖ 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)?
(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 _____