Pediatric Client Intake Form

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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.	REASON	STARTED	DOSAGE
example: Vitamin C	*colds*	*10/2003*	*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 _____

Pathways to Health, L.L.C.

Consent to Treatment Form and Client Agreement

Practitioner: Marcus Walther, LMT, BCTMB
| Licensed Massage Therapist | Board Certified in Therapeutic Massage & Bodywork |
| Craniosacral Therapist | Energy Medicine Practitioner | Licensed Minister |

Status and Scope of Practice

I am a Licensed Massage Therapist in the Commonwealth of Virginia, Board Certified in Therapeutic Massage and Bodywork (NCBTMB) since 2006, a Craniosacral Therapist, Energy Medicine Practitioner, and Licensed Minister. I offer therapeutic massage, craniosacral therapy, energy balancing, and spiritual coaching services.

I provide services for both adults and children. For all pediatric sessions, parental or guardian consent and presence are required. Please note: while the child receives the session, the parent or guardian is considered the client of record.

These services are intended to promote relaxation, ease physical and emotional tension, and support overall well-being. I am not a physician, chiropractor, or mental health provider and do not diagnose, prescribe, or treat medical conditions. Clients are encouraged to maintain regular care with a licensed healthcare provider. Massage is not a substitute for medical diagnosis or treatment.

Description of Services

Massage Therapy

Massage therapy involves the manual manipulation of soft tissues to ease muscular tension, promote relaxation, improve circulation, and support emotional well-being. Sessions may incorporate a variety of techniques including, but not limited to: Swedish Massage, Deep Tissue Massage, Myofascial Release, Reflexology, Craniosacral Therapy, Trigger Point Therapy, assisted stretching, and other recognized massage methods as appropriate to client needs.

Craniosacral Therapy

A gentle, hands-on modality that focuses on the craniosacral system — the membranes and fluids surrounding the brain and spinal cord. The goal is to reduce restrictions, ease tension, and support balance in the central nervous system. This therapy is typically performed with the client fully clothed, but may be any comfort level of clothing with proper draping.

Energy Balancing

Energy Balancing is a non-invasive modality involving the evaluation and manipulation of the human energy field. Using the client's or practitioner's energy field, this work is intended to effect change in the client's energy field to help support their overall mental, emotional, physical, or spiritual health. Energy Balancing is a complementary service and is not intended to replace professional medical care.

Spiritual Coaching

As a Licensed Minister, I may offer spiritual coaching for clients seeking emotional, life-purpose, or spiritual guidance. Spiritual coaching is designed to complement — not replace — other therapeutic or medical services.

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Benefits & Risks
Potential benefits of these services include stress reduction, relief from muscular tension, improved circulation, enhanced flexibility, support for emotional balance, and activation of the body's self-healing mechanisms. Risks are minimal but may include temporary soreness, emotional release, fatigue or lightheadedness. Clients are encouraged to communicate openly and stop the session at any time if discomfort arises. Clients are responsible for informing the practitioner of any health conditions, medications, or changes before each session.

Education, Credentials, & Experience
- Licensed Massage Therapist (Virginia)
- Board Certified in Therapeutic Massage & Bodywork (NCBTMB) since 2006
- Trained in Craniosacral Therapy
- Licensed Minister
- Specialized training in Energy Balancing, Reflexology, and additional therapeutic techniques.

Further details on my background and ongoing professional education can be found on my LinkedIn profile.

Confidentiality
All personal and health information shared during treatment is confidential and will only be disclosed with written permission or as required by law.

Client Rights
You have the right to ask questions, modify or withdraw consent at any time, and expect professional, respectful conduct in all interactions.

Fees & Payment
Payment is due at the time of service unless prior arrangements have been made. Missed appointments or cancellations with less than 24 hours' notice will be charged the full session fee, except in the case of emergencies or extenuating circumstances, at the discretion of the practitioner.

Client Consent
I have read and fully understand the information above. I have had the opportunity to ask questions, and I consent to receive therapeutic massage, craniosacral therapy, energy balancing, and/or spiritual coaching services from Marcus Walther at Pathways to Health, L.L.C. I understand that no specific outcome has been promised or guaranteed. Except in the case of gross negligence or malpractice, I or my representative(s) agree to fully release and hold harmless Marcus Walther and Pathways To Health, L.L.C. from and against any and all claims or liability of whatsoever kind or nature arising out of or in connection with my session(s).

Client Name (Printed): _____ Date: _____
Client Signature: _____
Address: _____
City/State: _____ Phone: _____
Practitioner Signature: _____ Date: _____

Consent to Treat Minor (if applicable)
I hereby authorize practitioners at Pathways to Health, L.L.C. to provide massage, craniosacral therapy, energy balancing, spiritual coaching, or other therapeutic services to my child or dependent.

Child's Name: _____ DOB: _____
Parent/Guardian Signature: _____ Date: _____
Printed Name of Parent/Guardian: _____