livewell health & wellness

LiveWell Health and Wellness
18 Snyder's Rd W, Unit 5
Baden ON, N3A 4G8

Pediatric Client Intake Form

Childs Name____ Date of Birth_____________________Age________
Parent(s) Name(s)____
Parent Occupation/Employer ____
Email____ Cell Phone___________________________
Home Phone ________________________ Work Phone________________________Extension_________________
Address:____
Street City Province Postal Code

Has child received massage therapy before? ☐ Yes ☐ No

How did you hear about me? ☐ Friend/Family ☐ Healthcare Professional ☐ Event ☐ Other____________________
Name of person who referred you_________________________________

Please mark your goals for your child's Pediatric Massage Treatment Plan:

- ☐ Provide Comfort
- ☐ Promote relaxation
- ☐ Reduce stress
- ☐ Reduce pain
- ☐ Ease Depression
- ☐ Decrease anxiety
- ☐ Reduce muscle hyper tonicity
- ☐ Improve muscle tone (decrease hypo tonicity)
- ☐ Improve gastrointestinal functioning
- ☐ Improve joint mobility / range of motion
- ☐ Promote orientation of extremities toward midline
- ☐ Improve pulmonary functions
- ☐ Reduce chronic fatigue
- ☐ Reduce lethargy
- ☐ Reduce colic / chronic abdominal pain
- ☐ Promote growth for baby born prematurely/child
- ☐ Improve self-soothing behavior
- ☐ Improve attentiveness and responsiveness
- ☐ Improve sleep patterns
- ☐ Decrease hypersensitivity to touch
- ☐ Enhance child's body awareness
- ☐ Promote parent-child bonding

Other Goals: ____

Health History

Postpartum complications? ☐ No ☐ Yes (describe):

Is your child currently under the care of a primary healthcare provider? ☐ Yes ☐ No

Name of healthcare provider: ____
Name/Location of healthcare facility: ____
May I exchange information when necessary with this provider? ☐ Yes ☐ No

How is your child's health in general?

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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, tendonitis, spasms, cramps, etc.) Type ___________________________ Location _________________________	☐	☐	**Circulatory Conditions** (includes heart, blood pressure, arteries and venous conditions, etc.) Type ___________________________ Location _________________________
☐	☐	**Joint Conditions** (includes sprain, 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 _________________________	☐	☐	**Cancer** Type___________________________ Location_________________________ Treatment:
☐	☐	**Autism/Spectrum** Describe:	☐	☐	**Cerebral Palsy** Symptoms:

Other medical conditions, symptoms and/or further explanations ____
____

Is your child taking any medication? Please list____
____

My child is sensitive/allergic to the following scents/oils/lotions____
or ☐ No known sensitivities

 Child's Name: ______________________

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Please list other complementary therapies or educational programs in which your child participates________________
____

May I exchange information when necessary with these providers? ☐ Yes ☐ No

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING TODAY?

☐ Sunburn
☐ Headache
☐ Cold/flu
☐ Diarrhea or other sickness
☐ Inflammation
☐ Open cuts, bruises, burns
☐ Contagious condition
☐ Infection
☐ Severe pain
☐ Irritated skin rash
☐ Fever
☐ Recent immunization/vaccination (wait 48 – 72 hours)

Is there anything else you would like me to know?

When the child receives a massage, she/he will not be touched in any area that would usually be covered by a bathing suit, aside from the upper back (shorts for boys, two-piece bathing suits for girls). Is there any other area that your child does not want touched?____

Consent for Child to Receive Massage Therapy

I understand that my child will be participating in pediatric massage therapy as a form of adjunct health care, and that massage is not a substitute for medical examination and treatment/care by my child's doctor, and that no diagnosis will be made. I have noted above all complications, risks, or conditions my child has experienced. I recognize the importance of updating the massage therapist on changes in my child's health.

I realize that massage will only be provided with the permission of my child in that moment. If my child does not wish to receive massage or be touched, her/his wish will always be honored, even if part-way through the session. If this is the case, the session time can be used for the parent to learn basic massage techniques, and connecting with the child to see if interest in receiving massage can be encouraged or regained. By my signature below, I give consent for my child to receive massage therapy.

No Show Policy

If I am unable to attend my scheduled appointment time, I will provide the clinic with 24 hours notice so that the clinic may utilize my time for another client seeking treatment. If I fail to give this notice, I agree to pay the full scheduled fee. If I am late arriving for a scheduled appointment time, I will receive a shortened treatment at full scheduled fee.

Signed ____ Date _____________________

Parent/Legal Guardian of ____