# Attentive Touch

Your natural alternative to improved mental and physical health.

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PEDIATRIC MASSAGE - CLIENT INTAKE FORM (18YRS AND YOUNGER) Date: _____

Child's Name: _____ M ( ) F ( ) Date of Birth: _____

Parent's Name(S): _____

Street Address:_____

City:_____State:_____Zip:_____

Phone:_____Cell:_____

Email: _____

What is the best way to contact you? _____phone _____email
(You will only be contacted as it pertains to billing or your child's session.)

Emergency contact name and number: _____

Who referred you? Name:_____

Please mark goals for you child's pediatric massage program:

| | | |
|---|---|---|
| __Provide comfort | __Promote relaxation | __Reduce Pain |
| _ Ease depression | __Reduce muscle hyper tonicity | __Improve muscle tone |
| __Reduce stress | __Decrease Anxiety | __Reduce chronic fatigue |
| __Improve gastrointestinal functioning | __Improve joint mobility/range of motion | __Promote parent-child bonding |
| __Increase energy/Reduce lethargy | __Improve attentiveness or responsiveness | __Improve sleep |
| __Decrease hypersensitivity to touch | __Encourage vocalization | __Enhance child's body awareness |
| __Improve pulmonary functions | | |

Other goals:_____

_____

How do you feel your child is developing?: _____

_____

Has there been a medical diagnosis? ____no ____yes - If Yes:_____

Have you had x-rays taken if applicable? ____no ____yes

**Health History**

Birth History: ____Biological Child ____Adopted Child ____Foster Child

Weeks gestation: ____ Delivery: ____Vaginal Forceps ____C-Section ____Vacuum Extraction

Postpartum complications: ____no ____yes (describe:)_____

Is your child currently under medical or therapeutic treatment? ____no ____yes

If yes, for what condition_____

Name and number of Doctor: _____

May I exchange information when necessary with this provider? ____no ____yes

Please list any medication (including aspirin, ibuprofen, etc.) and nutritional supplements your child is taking:

Medication/Herb_____ Reason_____ Date Started_____ Dosage_____

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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:

***Skin Condition*** (include rashes, topical allergies, fungal infections etc..): __now __past

Type:_____ Location:_____

***Muscle Condition*** (includes strains, tendonitis, spasms, cramps): __now __past

Type:_____ Location:_____

***Joint Condition*** (includes sprain, arthritis, degenerating joints): __now __past

Type:_____ Location:_____

***Nervous System*** (includes numbness, tingling, nerve damage, shingles etc..): __now __past

Type:_____ Location:_____

***Respiratory*** (includes sinus, long and bronchial etc..): __now __past

Type:_____ Location:_____

***Circulatory*** (includes heart, blood pressure, arteries and venous etc..): __now __past

Type:_____ Location:_____

***Reprroductive*** (includes pregnancy, prostate, menstruation): __now __past

Type:_____ Location:_____

***Digestive*** (includes constipation, diarrhea, ulcers): __now __past

Type:_____ Location:_____

Please list any accidents, illnesses or injuries in the last 2 years or older that are still effecting your child:_____

Please list any dietary or nutritional considerations (gluten free diet, allergies etc...)_____

**Therapeutic History**

Has your child previously had a massage, Cranial Sacral Therapy, or other bodywork? ____no ____yes

If so, what type? _____

Please list complimentary therapies or educational programs in which your child participates:

Therapy/Program_____ Reason_____ Started_____ Practitioner_____

Therapy/Program_____ Reason_____ Started_____ Practitioner_____

Therapy/Program_____ Reason_____ Started_____ Practitioner_____

May I exchange information with these providers? ____ no ____yes

Has your child been evaluated for or diagnosed with Sensory Integration Disorder? ____no ____yes

If yes, please explain evaluation, diagnosis, and/or therapy program:_____

_____

How does your child respond to touch/movement?

| | 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? | | | | | | |
| Lack awareness of being touched? | | | | | | |
| Bite, chew, or suck on blanket/pacifier/etc...? | | | | | | |
| Frequently bump into or push people or items? | | | | | | |
| Have 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 (i.e. on stairs, heights, etc)? | | | | | | |
| Dislike being off balance? | | | | | | |

**Personal History**

Please describe your child's communicating style:

___Verbal ___Word Approximations ___ASL ___PECS ___Augmentative Device ___Gestures ___None Other_____

How does your child deal with change?_____

How does your child handle stressful situations (self-soothing techniques)?_____

_____

What makes your child…: (And how do you deal with it?)

Happy? _____ _____

Sad? _____ _____

Angry? _____ _____

Stressed? _____ _____

Excited? _____ _____

Does your child attend preschool/daycare/school? ____no ____yes

Name of teacher(s)? _____

Name/type(s) of pet(s)? _____

Names of his/her sibling(s)?_____

Names of his/her friend(s)? _____

What type of exercises interest your child? _____

How does you child prefer to spend his/her time? _____

I have listed all my child's known medical conditions and physical limitations and will inform Attentive Touch in writing of any changes between bodywork sessions. I understand that Attentive Touch 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 and will refer us elsewhere if she feels it's appropriate. I am responsible for consulting a qualified primary care provider for any physical ailments that my child may have.

I agree I will give Attentive Touch 24 hrs. notice whenever possible to cancel any bodywork session. I have read and agree to her Patient Policies.

Signed:_____ Date:_____

Parent/Legal Guardian of: _____