Pediatric Questionnaire and Consent Form

Child's Name: _____ Birthdate: _____ Age: _____

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

Work Phone: _____ Mobile Phone: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Parent Occupation/ Employer: _____

Please check your goals for your child's Pediatric Massage Program:

___ Provide Comfort
___ Promote Relaxation
___ Reduce Stress
___ Reduce Pain
___ Ease Depression
___ Decrease Anxiety
___ Reduce muscle hypertonicity
___ Improve muscle tone (decrease hypo tonicity)
___ Improve gastrointestinal functioning
___ Improve joint mobility / range of motion
___ Promote orientation of extremities towards midline
___ Reduce chronic fatigue
___ Improve pulmonary functions
___ Decrease symptoms of atopic dermatitis
___ 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
___ Encourage vocalization
___ Enhance child's body awareness
___ Promote parent-child bonding

Other Goals: _____

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

___ Different then an average child his/her age in any area of development

Please list medications, supplements or homeopathies the child is NOW taking:

Medications/Herbs/Etc.	Reason	Started	Dosage
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please mark any of the following that your child has had or has had in the past. Identify the condition and location where applicable.

Now	Past	Condition
____	____	**Skin Conditions** (includes rashes, topical allergies infections, etc.)
		Type: _____ Location: _____
____	____	**Muscle Conditions** (includes strains, tendonitis, spasms, cramps)
		Type: _____ Location: _____
____	____	**Joint Conditions** (includes sprains, arthritis, degenerating joints)
		Type: _____ Location: _____
____	____	**Nervous System Conditions** (includes numbness, tingling, nerve damage, shingles, etc.)
		Type: _____ Location: _____
____	____	**Infectious/Communicable Conditions**
		Type: _____ Location: _____

Now	Past	Condition
____	____	**Respiratory Conditions** (includes sinus, lung and bronchial conditions, etc.)
		Type: _____ Location: _____
____	____	**Circulatory Conditions** (includes heart, blood pressure, arteries and venous conditions,etc.)
		Type: _____ Location: _____
____	____	**Reproductive Conditions** (includes pregnancy, prostate, menstruation)
		Type: _____ Location: _____
____	____	**Digestive Conditions** (includes constipation, diarrhea, ulcers)
		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 your 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 complimentary therapies or educational programs in which your child participates:

Therapy/Program	Reason	Started	Practitioner
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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:

Personal History

	Never	Some	Often	Always	In the Past	This is a problem
Dislike being held or cuddled?						
Seems irritated when touched?						
Bang or hit head on purpose?						
Have an increased response to pain?						
Lack awareness of being touched?						
Bite, chew or suck on blanket/pacifiers/ 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 a fear in space (i.e. on stairs, heights, etc.)?						
Dislike being off balanced?						

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)? _____

_____

_____

What makes your child: (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? _____

How does your child prefer to spend his/her time (hobbies/interest)? _____

_____

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 massage therapist must be aware of any and all existing physical conditions that my child has in order to provide appropriate massage. I further understand that a massage therapist neither diagnoses nor prescribes for illness, disease and any other medical, physical or emotional disorder, nor performs any 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 24 hour notice to cancel any bodywork session to avoid being charged.

Printed Name: _____ Date: _____

Signature: _____ Date: _____

Parent/ Legal Guardian of _____

Pediatric Massage Consent Form

Child's Name: _____ Birthdate: _____

Caregiver's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Cell/Pager: _____

Email: _____

Referred By: _____

In case of Emergency

Name: _____ Phone: _____

My healthcare provider is: _____ Phone: _____

Contraindications for Pediatric Massage:		Common Precautions for Pediatric Massage:
* Fever/Temperature * Acute infection, staph infection, illness or disease * Skin disorders/condition which may be contagious or cause inflammation (fungus, rashes, herpes) * Open sores, wounds or lesions * Recent immunizations/vaccinations **(wait 48-72 hours)** * Life threatening medical condition * Unhealed umbilical cord (tummy massage contraindicated) * Swollen lymph nodes * Blood clots or blood conditions * Diarrhea or other sickness * Inflammation * High blood pressure * Hernia * Osteoporosis * Varicose Veins * Broken Bones * Deep Vein Thrombosis * Pain * Lability * Thrombocytopenia		* Apnea * Bradycardia * Tachycardia * Abdominal Distention * Gastrointestinal or Jejunostomy feeding tubes * Hydrocephalus * Inflammation * Edema * Dysplasia * Hemophilia * Jaundice * Recent Surgery * HIV/AIDS * Tumors * Cancer * Seizure Disorders * Agitation * Impulsivity

Please indicate any of the high risk factors, complication that I should be aware of: _____

_____

_____

Is there other relevant information about the pregnancy, child birth, about you and your child that I should know? _____

_____

_____

I, _____ understand that my child will be participating in pediatric massage therapy as a form of adjunct healthcare.

I have noted above all complications, risks, or conditions my child has experienced AND I have obtained my child's healthcare providers release.

I understand that my child will receive pediatric massage therapy as a form of adjunctive healthcare only and that it is not a substitute for other healthcare provided by a medical doctor or other licensed provider.

I hereby release and hold harmless and defend the practitioner from any claims, liability, demands and cause of action from my and my child's participation in this therapy.

Printed Name: _____ Date: _____

Signature: _____ Date: _____

Practitioner's Signature: _____ Date: _____

Practitioner's Contact Information:

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