Free Spirit Massage & Doula Services, LLC
205-A Old Perry Road, Bonaire, GA 31005
(478) 365-7857

Pediatric Massage Intake Form - CONFIDENTIAL INFORMATION

Child's Name _____ Birthdate _____
Age _____ Parent(s) Name(s) _____
Home Phone (____)_____
Work Phone (____)_____ Cell Phone (____)_____
Street _____ City_____ State ____ Zip _____
Parent Occupation/Employer _____
Parent email _____
How did you hear about Free Spirit Massage & Doula Services, LLC?
_____

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

__ 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
__ 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

Weeks gestation: _____ Delivery: Vaginal Forceps C-Section Vacuum Extraction
Post-partum 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 homeopathies the child is now taking:

Medication/Herb/Etc.	Reason	Started	Dosage
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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 _____	____	____	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, massage*) Yes No
If yes, please explain: _____

Please list other complementary 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:

	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?						

	Never	Some	Often	Always	In the past	This is a problem
seem overly aware of touch, texture or temperature?						
bite, chew or suck 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 (i.e. on stairs, heights, etc.)?						
dislike being off balance?						
have an increased response to pain?						
lack awareness of being touched?						

Personal History

Please describe your child's communication style: (Circle)
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:		(and how do you deal with it?)
Happy?	_____	_____
Sad?	_____	_____
Angry?	_____	_____
Stressed?	_____	_____
Excited?	_____	_____

Does your child attend school/preschool/daycare? Yes No
If yes, what _____
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.

Signed _____ Date _____

Print name _____

Parent/Legal Guardian of _____

Relation to minor _____

The following sometimes occurs during massage. They are **normal** responses to relaxation. Trust your body to express what it needs to:

*need to move or change position *****sighing, yawning, change in breathing stomach gurgling * emotional feelings and/or expression
movement of intestinal gas * energy shifts * falling asleep * memories

Please read the following information and sign below:

1. I understand that although massage therapy can be very therapeutic, relaxing and reduce muscular tension, it is not a substitute for medical examination, diagnosis and treatment.
2. This is a therapeutic massage and any sexual remarks or advances will terminate the session and I will be liable for payment of the scheduled treatment.
3. Being that massage should not be done under certain medical conditions, I affirm that I have answered all questions pertaining to medical conditions truthfully.

Cancellation/reschedule policy:
Booking a session with me, you agree to my policies. All policies are posted on my website as well.

1. Cancel / reschedule your appointment with at least 24 hours notice: no charge
2. Cancel / reschedule your appointment within 24 hours of your appointment for any reason: 50% of the full un-discounted rate. You can avoid this by sending someone in your place! If you are able to fill this appointment: no charge
3. Cancel / reschedule your appointment within 3 hours: Full charge, unless we can re-book that slot.
4. No show / No notice: If you do not show up for any reason, with no notice, you will be charged full price of the session booked.
5. If you are late for your scheduled session; your session starts without you. You will receive the remaining time you scheduled, but will pay for the full time slot booked. Arrive early so that your session can start on time.
6. Due to recent events with COVID, if you arrive at your appointment showing signs of **ANY** illness, you will be sent home and charged for the appointment. Please call the moment you show signs of illness to avoid any charges.

Signature: _____ Date: _____

Print Name: _____

Relation to Minor: _____

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Minor Consent Form - CONFIDENTIAL INFORMATION

Minors are permitted to receive massage therapy by Courtney Coley, LMT of Free Spirit Massage & Doula Services, LLC.

Parent or legal guardian must be present in helping complete the Health History Form for the minor, along with consent for the massage therapy session.

Guidelines:

· Minors (all clients under the age of 18 – unless otherwise emancipated) can only receive massage with written parental/legal guardian consent.

· In collaboration with the consenting adult and child, the massage therapist will assist in establishing goals for the session(s).

· For clients age 15 and under, the parent/guardian must be present in the treatment room for a minimum of the first session.

· Once a comfortable therapeutic relationship has been established and the massage therapist, child and parent are comfortable the parent/legal guardian does not have to be present in the room.

· For clients age 16-17 if both client and parent/guardian are comfortable with the child being in the session room by themselves, please initial and date here._____

· Appropriate draping will be used at all times during the massage and only the areas being massaged are uncovered and then covered again before moving to the next area.

I, _____, am the parent/legal guardian of _____. I have read the above information and give permission for my child, age _____, to receive massage therapy from __Courtney Coley, Free Spirit Massage & Doula Services, LLC__.

_____ _____
Signature Date

_____ _____
Print name Relation to minor

_____
Print Minors name