SAFE, SMART, EFFECTIVE HEALTH CARE

Arnica Clinic
308-12099 Harris Rd, Pitt Meadows, BC V3Y 0E5
Ph: 604-457-3335
info@alonarmt.com

PEDIATRIC MASSAGE THERAPY INTAKE FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Gender ☐M ☐F
Date(Month / Date / Year)

Care Card #: _____ _____ _____ Extended Medical Insurer: _____
Parent / Guardian Name:_____
Relation:_____
Address: _____
City: _____ Prov.:_____ Postal Code: _____ _____
Home Phone: _____-_____-_____ Cell Phone: _____-_____-_____
Email Address:_____
Daytime Caregivers Name: _____
Language(s) Spoken In Home: _____
Language(s) Spoken By Caregivers: _____

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 child's body awareness
☐Promote parent-child bonding

Describe your primary or other concern(s) regarding your child?:

_____

_____

_____

_____

_____

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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? ☐No ☐Yes
Name of healthcare provider: _____
Name of healthcare facility: _____
Location: _____ Phone: _____-_____-_____

May I exchange information when necessary with the provider? ☐Yes ☐No

My child is developing:
☐like an average child or 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 homeopathic the child is taking past or present:

Medication / Herb / etc.	Reason	Past / Present	Dosage
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please mark any of the following that your child now has or has had I 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) Type _____ Location _____	☐	☐	**Circulatory Conditions** (Includes heart, blood pressure, arteries and venous conditions, etc.) Type _____ Location _____

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Now	Past	Condition	Now	Past	Condition
☐	☐	**Joint Conditions** (Includes sprain, arthritis, Degenerating joints) Type _____ Location _____	☐	☐	**Reproductive Conditions** (Includes pregnancy, prostate, menstruation) Type _____ Location _____
☐	☐	**Nervous System Conditions** (Includes numbness, tingling, Nerve damage, shingles, etc.) Type _____ Location _____	☐	☐	**Digestive Conditions** (Includes constipation, diarrhea, ulcers) Type _____ Location _____
☐	☐	**Infectious or Communicable Conditions** Type _____ Location _____	☐	☐	**Other Conditions** (Includes any other health conditions Not previously listed) Type _____ Location _____

Other medical conditions, symptoms and / or further explanations:

_____

_____

Please list any recent accidents, significant illnesses and infections (give approximate dates) :

_____

_____

Please list any special dietary / nutritional considerations or allergies (food and nonfood) :

_____

_____

How do these symptoms affect the child's daily life?:

_____

_____

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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)
☐No ☐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 this provider? ☐Yes ☐No

Has your child been evaluated for or diagnosed with Sensory Integration Disorder?
☐No ☐Yes (Please 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?	☐	☐	☐	☐	☐	☐
Lack awareness of being touched?	☐	☐	☐	☐	☐	☐
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?	☐	☐	☐	☐	☐	☐

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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)?
_____

What makes your child	(And, how do you deal with it):
Happy? _____	_____
Sad? _____	_____
Angry? _____	_____
Stressed? _____	_____
Excited? _____	_____

Does your child attend school / preschool / daycare? ☐ No ☐Yes
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 sibling? _____

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)?

_____

_____

_____

_____

_____

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SIGNATURES:

Dear Parents,

Please Note: Your appointment time has been reserved for you. In courtesy of your therapist & fellow patients, we ask that you provide us with 24 hours notice of cancellation, or you will be billed in full for your missed appointment.

I authorize the clinic and its associated RMTs to collect my personal and medical information as documented above in order to contact me, and give permission for the clinic to leave messages regarding appointments at any of the contact numbers I have provided above. In addition, I authorize the clinic and its associated RMTs to communicate with my referring MD as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

I , _____ (parent or guardian name), _____ (relation to child), 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 my child has 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 a physical ailment that my child may have.

_____ _____ _____
Signature (Parent / Guardian) *Please Print Name* *Date*(Month / Date / Year)

ATTENDANCE POLICY

I agree to give 24 hours notice when canceling a set appointment.

_____ _____ _____
Signature (Parent / Guardian) *Please Print Name* *Date*(Month / Date / Year)

_____
Child's Name

To cancel appointment:
info@alonarmt.com