Pediatric Confidential Intake Form

Name:_____

Address_____Town_____

State_____Zip_____ Date of Birth_____ Age_____

Parents Names_____ _____

Home Phones_____ _____

Work Phones_____ _____

Cells_____ _____

Emails _____ _____

Parents' Marital/Relationship status_____Referred by_____

Client Confidentiality and Release Form

I understand this modality is not a replacement for medical care. The practitioner does not diagnose medical illness, disease or other physical or mental conditions. As such, the practitioner does not prescribe medical treatment of pharmaceuticals, nor does he/she perform spinal manipulations. The practitioner may recommend referral to a qualified health care professional for any physical or emotional conditions I may have. I have stated all my known conditions and take it upon myself to keep the therapist/practitioner updated on my health.

Confidentiality of medical and personal information obtained during the course of the practitioner's work is of the utmost importance. HIPAA regulations require all practitioners obtain a signed release form from their client *before* taking any information about them. The best way to be fully compliant is to obtain this release signature at the initial consultation. Clients should receive a copy of the form they signed (upon request), and the practitioner maintains a copy for their records

I, (name)_____

give my permission, for my practitioner to take notes including health history/ medical and /or personal information I choose to disclose to him/her.

Client Signature: _____ Date: _____

Practitioner signature_____Date:_____

Client Name:

Reason For Visit

Primary reason for visit:_____

When did your first notice it?_____What brought it on?_____

Describe any stressors occurring at the time_____

What activities provide relief?_____what makes it worse?_____

Is this condition getting worse?_____interfere with work_____sleep_____ recreation_____

Have you had massage/bodywork before?_____What type?_____

Medical History

Child's gender assigned at birth_____ Child's preferred gender_____

Are you currently under the care of another health care provider(s)?_____Reason (s)_____

_____

Name(s) of Practitioner_____Address:_____

Phone_____email_____

Current Medications and /orSupplements/Remedies:_____

_____

Allergies: specify allergen and reaction:_____

Surgical History (year and type) and/or Recent Procedures:_____

_____

Hospitalizations: _____

Accidents or Traumas_____

Falls/Injuries to Sacrum/head/tailbone (describe)_____

Other:

 Please review and check the following:

Headaches Type:	Past	Present	Numbness in feet or legs when star	Past	Present
Asthma			Sore heels when walking		
Cold Hands or feet			Anxiety		
Swollen ankles			Depression		
Sinus Conditions Frequent Colds			Sleep Disturbance		
Seizures			Fainting Spells		
Low Back Pain			Muscular Tension: Location:		
Skin Disorders: Type			Varicose Veins Hemorrhoids Location		
Sciatica			Herniated/Bulging Discs		
Painful/Swollen Joints			Artifical/Missing limbs		
High or Low Blood Pressure			Contact Lenses		
Dentures/Partials			Cancer (past or current) Type		

Family History

	Still Living?	**Cause and Age of Death**	**Major Health Issues**
Mother			
Father			
Siblings			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandfather			
Paternal Grandmother			

Gastroinstestinal Health History

Describe your typical:

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____Water Intake(glasses/day)_____Caffeine_____

What is the worst item in your diet_____What foods are your weakness_____

Are you subject to binge eating?_____What foods_____

Do you experience bloating/gas/burps after eating?_____What foods trigger this?_____

Food Allergies?_____Describe_____

How often are your bowel movements?_____Do your stools: sink_____float_____

Constipation?_____Blood in stool ?_____Mucus in stool?_____Pain when stooling?_____

Diarrhea?_____Other?_____

Lifestyle, Emotional & Spiritual

What is your opinion of yourself?_____

Describe the most positive emotion you experience_____

When and Where do you experience this emotion?_____

Describe the most negative emotion you experience_____

When and Where do you experience this emotion?_____

Describe your Spiritual and/or Religious practice:_____

On a scale of 1 – 10 *(1 being the lesser, 10 the greater*) Please rate yourself in each of these qualities:

Faith_____Hope____Charity____Generosity_____ Sense of Humor_____Fear_____Grief_____Sense of Fun_____

What hobbies/ activities provide you with pleasure and accomplishment _____

Describe your exercise routine (type, frequency)_____

What changes would you like to achieve in 6 months:_____

One Year**:**_____

Do you use Tobacco?_____ Quantity_____/ppd Alcohol?_____Quantitiy_____ounces/ day

Marijuana?_____Quantity_____Other:_____ Have you been under treatment for substance use?

Pregnancy and Birth

Was your child conceived with fertility assistance?

Was your child adopted? If so, what were the circumstances?

If known, please describe the mother's experience during your child's pregnancy:

Birth Care Provider_____ Place of Birth_____

If known, please describe the labor and birth of your child:

If known, please describe the first few months of your child's development:

Was your child gassy or "colicky"?

Please describe your baby's feedings (breast or bottle, schedule, etc)

As your child has grown, have there been any developmental concerns?

Consent for Massage Therapy

New York State Consumer Information: Who are massage therapists?

Massage therapists are licensed health professionals who apply a variety of scientifically developed massage techniques to the soft tissue of the body to improve muscle tone and circulation. Massage therapists work to enhance well-being, reduce the physical and mental effects of stress and tension, prevent disease, and restore health.

New York State Statute: § 7801. Definition of practice of massage therapy

The practice of the profession of massage therapy is defined as engaging in applying a scientific system of activity to the muscular structure of the human body by means of stroking, kneading, tapping and vibrating with the hands or vibrators for the purpose of improving muscle tone and circulation.

Massage Therapy Consent:

The client understands that . . .

- The relationship between the client and the massage therapist is a confidential one and that all information provided to the therapist is to be kept confidential.
- The massage therapist will respect the patient's/client's right to an informed and voluntary consent for the release of patient/client information.
- The massage offered is solely for therapeutic reasons and both the client and the massage therapist have the right to be free from any unwanted, harmful and/or offensive (physical or other) behavior.
- The client's body will be properly draped at all times for comfort, security and warmth. Only the body areas receiving immediate therapy will be undraped.
- The massage therapist will respect the patient's/client's right to refuse, modify or terminate treatment, regardless of prior consent for such treatment.
- The massage therapist will not cause the patient/client more pain than the patient/client is willing to accept, nor will they exert any psychological pressure to induce the patient/client to accept a level of pain higher than the patient/client has expressly agreed to experience.
- It may be necessary to obtain permission from the client's healthcare provider (primary care or other physician) to receive or continue therapy.
- The client will inform the massage therapist of any discomfort during the massage session, so that the application of pressure or strokes may be adjusted to my level of comfort.
- The client understands that massage is a touch modality and may trigger strong emotional responses in the client. The client will immediately inform the massage therapist of any emotional discomfort.
- Therapeutic massage is an ancillary treatment and is not intended as a primary medical treatment.
- The massage therapist does not diagnose conditions and I may be asked by my therapist to contact my primary care physician to receive a proper diagnosis.
- Should the client have to cancel an appointment for any reason, I agree to give the massage therapist notification at least 24 hours in advance of that appointment.
- The client freely gives permission to receive massage therapy treatment.

Client (print please): _____ Date: _____

Client (or guardian): _____(signature)

Massage therapist: _____ Date: _____