Alchemy Healing Arts Center, LLC

PEDIATRIC NEW CLIENT INFORMATION

Therapist___________________

Child's Name____ Date of Birth__________________________

Parent's Name ____ Today's Date__________________

Address ____

City ____ State _____ Zip _____________

Occupation ____ Employer _________________________

Family – Other Kids, Creatures?____

Email Address ____ May we add you to my mailing list? _____

Best Phone to Contact ____________________________C-W-H? Alternative Contact # __________________

Emergency Contact – Name_______________________________________ Phone#________________________

How did you learn about us? _____________________________ May we thank them for their referral?_______

Have your child received Professional Massage Therapy or Bodywork before? _____________________________

What Kinds? ____ How often? _______________________

Please check off any of the following conditions or symptoms which apply to you now or in the past:

____ Nursing Concerns	____ Torticollis	____ Hypo or Hyperglycemia
____ Latch Issues	____ Ear Infections	____ Muscle Strain
____ Poor Suck Reflex	____ Ear tubes	____ Joint Sprain
____ Colic	____ Teeth Grinding	____ Notable Falls
____ Reflux	____ Jaw Clenching	____ Headaches - Migraines
____ Vomiting	____ Developmental Delay(s)	____ Constipation/Irregularity
____ Allergies (please list)	____ Tight Frenulum	____ Other Conditions

Details for Above:____

Birth Story____

____

Please list and explain other conditions/symptoms your child is or has experienced: _______________________

Have your child had any serious or chronic illness, surgeries, or traumatic accidents? ______________________

If yes, please give dates and details:____

____

Is your child currently experiencing any cold, flu-like, or other symptoms of infection? ______________________

In order to effectively provide Lymph Drainage Therapy please answer these questions about your child:
History of cancer? ______ Lymph nodes removed? _______ Radiation therapy?_______ Lymphedema? _________

Is your child currently, or was at any time within the last 12 months been under the care of a physician? If so, for what condition?____

Is your child on any medication? ___ If yes, which ones, and what condition are they prescribed for?_________

____

If appropriate, and with your knowledge, may we have permission to contact your Doctor / Therapist? ________

Doctor / Therapist Name: ____Telephone ________________________

What forms of play and exercise does your child enjoy regularly and how often?

____

How much water does your child drink daily____

What is your child passionate about? ____

What goals do your child, or you, have for this session? ______________________________________

Is there anything else that I should know about your child to best provide craniosacral, lymphatic drainage, and bodywork sessions for your child?

____

I have completed this health form to the best of my knowledge. I understand that Massage Therapy, CranioSacral Therapy®, Lymph Drainage Therapy® and other forms of hands on bodywork services are a therapeutic health aid. They do not take the place of a physician's care when indicated.

Any information exchanged during a session is confidential and is only used to provide you with the best health care services.

If I am not able to make a scheduled appointment, I agree to cancel the appointment 24 hours in advance by phone, unless I have a true emergency. In this case, I will call ASAP to reschedule my appointment.

I understand that if I miss a scheduled appointment without giving 24 hour notice, I agree to pay the full appointment fee.

For a minor, signature of Parent/Guardian is required:

Signature ____ Date ________________________