Minor's Intake Form – Therapeutic Massage

Personal Information:

Child's Name_____Today's Date_____

Parent/Guardian's Name_____

Home Phone_____CellPhone_____Work Phone_____

Address_____

City/State/Zip_____

Email_____Date of Birth_____/_____/_____ Gender_____

Physician/Healthcare Provider:_____Phone_____

How did you hear about us?_____

The following information will be used to help plan safe and effective massage sessions. Please answer the questions to the best of your knowledge.

1. Describe typical activities of daily living.

_____

_____

2. Has your child had a professional massage before? Yes No
   If yes, how often do they receive massage therapy?_____

3. Do they have any allergies especially to oils, lotions, or ointments? Yes No
   If yes, please explain_____

4. Are they currently taking any medications and/or supplements? Yes No
   If yes, please list_____

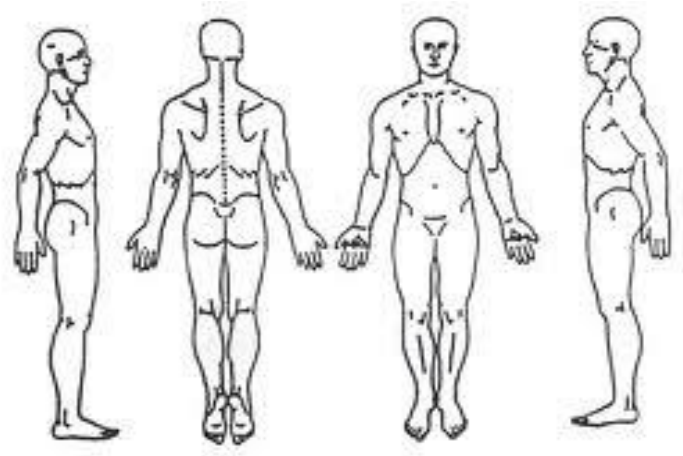
5. Do they have sensitive skin? Yes No

7. Do they perform any repetitive movement in their work, sports, or hobby? Yes No
   If yes, please describe_____

8. Please list past injuries or surgeries_____

10. Indicate any specific areas that are giving you current concern about your child, or that you would like the massage therapist to concentrate on during the session:

P = Pain, ache, tenderness
S= Stiffness in the joint or muscle



11. Rate how your child is feeling by drawing a circle around the number that best represents how they are doing today:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

Able to do Everything 0 1 2 3 4 5 6 7 8 9 10 Not Able to do Anything

12. Please check any health condition listed below that <u>currently</u> applies to your child.

( ) contagious diseases
( ) infections
( ) blood clots
( ) pitted edema
( ) congestive heart failure
( ) **None of the above applies to me**

Please explain any condition that you have marked above
_____
_____
_____

13. Please circle if your child has had any conditions stated below in the past or are currently experiencing these conditions.

Current Past Muscle or joint pain
Current Past Muscle or joint stiffness
Current Past Numbness or tingling
Current Past Swelling
Current Past Bruise easily
Current Past Sensitive to touch
Current Past High/Low blood pressure
Current Past Stroke, Heart attack
Current Past Varicose vein
Current Past Deep vein thrombosis
Current Past Diabetes
Current Past Endocrine/thyroid conditions
Current Past Depression, anxiety
Current Past Shortness of breath
Current Past Cancer
Current Past Neurological (e.g. MS, Parkinson's, chronic pain)
Current Past Memory Loss, confusion, easily overwhelmed
Current Past Epilepsy, seizures
Current Past Headaches, Migraines
Current Past Dizziness, ringing in the ears
Current Past Digestive conditions (e.g. Crohn's IBS)
Current Past Gas, bloating, constipation
Current Past Kidney disease, infection
Current Past Scoliosis
Current Past Broken bones

( ) **None of the above applies to me**

Please explain, including treatment received on the **current** conditions you have marked above

_____

_____

14. Is there anything else about their health history that you think would be useful for their massage practitioner to know to plan a safe and effective massage session for your child?

_____

_____

_____

Turn over for last page →

Consent for Treatment

If my child experiences any pain or discomfort during this session, my child will immediately need to inform the practitioner so that the pressure and/or strokes may be adjusted to their level of comfort. I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that my child should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which you are aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my child's known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my child's medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so.

Authorization to Treat a Minor

I, _____ the undersigning parent/guardian having legal custody/guardianship of _____, a minor, do hereby authorize Ideal Chiropractic and Therapeutic Massage to give Therapeutic Massage treatment to_____.

Ideal Chiropractic & Therapeutic Massage Policies

Late-Cancellations and No-Shows

We kindly ask that you give us 24 hour notice if you need to cancel an appointment or to change the length of your massage. **If making same day changes to the length of your massage, you will still owe the full amount for original massage booked**. Late-Cancellations and No-Shows leave gaps in our schedules that cannot be filled without timely notice. This notification courtesy enables us to schedule another patient and, in turn, maintains a higher availability of services for you, as well as others. **Late-cancellations and No-shows will be charged $50.00.** After-hour messages regarding cancellations may be left at (920) 907-1700.

Late Arrivals

In consideration of our scheduling commitments to other clients, we may need to reschedule any appointment for which you are more than 15 minutes late. You will be considered a no-show and charged accordingly.

By signing below, you give consent for child to receive treatment and acknowledge that you read and understand the policies stated above.

Print Name of parent/guardian _____

Signature of parent/guardian_____ Date_____