Pediatric Intake Form

Cori Escalante, Certified Massage Therapist

Client's Name: ____ Age: _________ Birthdate: _____________

Parent's Names: ____

Email Address: ____

Address: _________________________________ City: __________________ State: _____ Zip:_________

Phone (Primary): ___________________________ Phone: (Secondary): ____________________________

Emergency Contact (Name, Relation, Phone): ____

Whom may we thank for referring you? How did you hear of us? _____________________________________

Reason for seeking Craniosacral / Massage care? ____

Have you seen another practitioner for this condition? _______

List any other types of health care or medical treatment your child is currently receiving: __________________

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Has your child received Craniosacral Therapy before? _____________ Frequency? _______________________

Previous experience with bodywork, massage, acupuncture, chiropractic? ______________________________

Is this problem:

☐ Constant ☐ Intermittent ☐ Occasional ☐ Cyclical

How long has it persisted? ____

What it is at its worst, how does it make your child feel? ____

What have you done that has NOT worked? ____

What makes it worse? ____

Describe procedures, surgeries, or hospital stays: ____

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Were there any complications during pregnancy? ____

Was baby full term? ________________ Was baby breech? ___________

How was your birth? (check all that apply):

☐ Vaginal	☐ Long Labor	☐ Birth Center	☐ Epidural
☐ VBAC	☐ Short Labor	☐ Vacuum/Suction	☐ Pain Medication
☐ C-Section	☐ Hospital	☐ Forceps	☐ Pitocin
☐ Induced	☐ Home	☐ Non-medicated	☐ Other

Were there complications during delivery? ____

Was baby breastfed? If yes, duration? _____________ Did you baby arch back/neck when eating?

Issues with Latch? ____________________________ Preferred one side over the other? ________________

List any falls, bumps, bangs, or accidents: ____

____

How many rounds of antibiotics has your child taken? Last 6 months? _____________ Lifetime? ____________

Present prescription drugs: __________________________ Past prescriptions: ____________________________

Over the counter drugs (past 6 months): ____

Does your child currently have any of the following conditions?

☐ Scraps, Cuts, Wounds	☐ Contagious Disease	☐ Skin Condition	☐ Other: ___________
	☐ Cold / Flu / Covid	☐ Heart Condition	

Check any of the following conditions your child has experienced:

- ☐ Ear Infection
- ☐ Chronic Colds
- ☐ Recurring Fevers
- ☐ Headaches
- ☐ Growing Pains
- ☐ Scoliosis
- ☐ Torticollis
- ☐ Asthma
- ☐ ADD/ADHD
- ☐ Colic
- ☐ Constipation
- ☐ Digestive Problems
- ☐ Head Banging
- ☐ Seizures
- ☐ Tonsilitis
- ☐ Tongue/Lip Tie
- ☐ Other: ________________

As a child did any of the following occur? (Check all that apply)

- ☐ Fall from high place
- ☐ Car accident
- ☐ Play in a jumper
- ☐ Play in a walker
- ☐ Frequent crying spells
- ☐ Sleep issues
- ☐ Did not gain weight
- ☐ Reaction to medication or vaccine
- ☐ Stomach pains/issues
- ☐ Hyperactivity
- ☐ Learning difficulties
- ☐ Bed Wetting
- ☐ Allergies
- ☐ Leg/Knee Pains
- ☐ Frenectomy
- ☐ Other: _____________

Is your child involved in physical activities or sports? Which ones? ____________________________________

Anything else I should know? Anything else you'd like to share? ____________________________________

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CANCELLATIONS AND/OR MISSED APPOINTMENT POLICY

_____ (initial) I understand cancellations made with less than 24-hour notice, late arrivals, and no-shows are liable for the cost of the full session and will be charged.

CONSENT TO TREAT A MINOR CHILD

I give my consent for treatment of my child. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my child's health status. 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 forget to do so. I understand that the massage/bodywork is provided for the basic purpose of relaxation and relief of muscular tension. If I perceive that my child is experiencing any pain or is in distress during this session, I will immediately inform the practitioner so that the pressure or work may be adjusted or halted. I understand there is no guarantee of success or effectiveness of Massage Therapy and Craniosacral Therapy (CST). I understand that Massage Therapy and CST does not diagnose or treat disease, illness, or disorders of any kind, nor is it a substitute for medical diagnosis or treatment when such attention is needed.

Child's Name: ____________________________________ Date: ________________________________

Parent/Guardian's Printed Name: ________________________ Signature: ______________________________