Two Roads Massage Therapy LLC
Austin, Texas
Pediatric Massage Therapy
Health History Intake Form: Children and Teens

Child's Name: _____(nickname?) _____Today's Date:_____

Birth Date:_____ Age _____ Referred by:_____

Parent/Guardian's Name:_____

Address: _____

Work Telephone: _____ Cell Phone: _____ Home Phone: _____

Parent's Email: _____ Parent's Occupation/Employer_____

Note: All questions listed below pertain to the child/teen who will be receiving pediatric massage therapy. Information should be completed and signed by parent.

1. **What are some of your goals for this massage? Provide comfort ____ Promote relaxation ____ Reduce stress _____Reduce Pain ____ Ease Depression _____ Decrease anxiety ____Improve muscle tone ___ Improve gastrointestinal functioning _____ Improve joint mobility/range of motion _____ Improve sleep patterns ____Other (explain) _____**

2. **How would you rate your stress level on a scale of 1 (none) to 10 (very high) _____**

3. **Have you ever had a professional massage or other bodywork? _____ If so, what kinds?**

4. **How would you describe your general health?**

5. **Are you presently under the care of a healthcare provider? Yes ____ No _____**
   May I exchange information when necessary with this provider? Yes ____ No _____
   Name of healthcare provider/facility:
   Location: Phone:

6. **Please list any medications or supplements you take on a daily basis, the dosage and note what they are for. List any side effects, if any.**

7. **Please list any special dietary/nutritional considerations (ex: gluten-free diet, allergies).**

8. **Give details re: any recent accidents or illnesses (past 2 years or those still affecting you).**

9. **Exercise: How often? _____ What kinds? _____**

10. **Please circle any of the following conditions which you currently have or have experienced in the past, indicating dates. Some may be contraindications for massage and/or need for further talks.**

Systemic Infections: Mononucleosis_____ Hepatitis_____Other virus _____

Cardiovascular: High blood pressure _____ Low blood pressure _____
Other _____

Musculoskeletal: **Whiplash _____ Low back pain____ Strain/sprain _____**
Broken Bones____ Osteoporosis _____ Scoliosis ____
Foot Pain _____ Torn Ligaments/cartilage/tendons_____
Other_____

Neurological: **Headaches _____ Other_____**

Skin: **Eczema____ Burns_____ Rashes _____Other _____**

Endocrine: **Diabetes _____ Hypoglycemia_____ Other_____**

Respiratory: **Hay Fever ____ Asthma ____ Sinus _____ Other_____**

Reproductive: **Menstrual cramps_____ PMS _____**
Other_____

Digestive: **Constipation____ Diarrhea _____ Other _____**

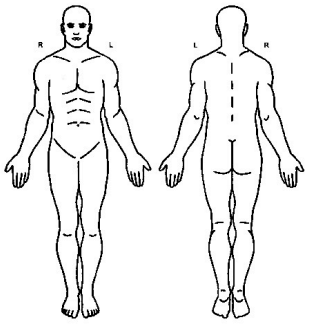
Urinary **UTIs _____ Other_____**

Cancer **Please describe with dates:_____**

Surgery **Please describe with dates:_____**

Other **Please describe any other conditions (with dates) _____**
_____

Please mark on the diagram your child's areas of greatest tension or discomfort.



It is my choice that my child is to receive a massage therapy session and my child agrees to it. I agree to communicate with the Practitioner if I ever feel my child's well-being is being compromised. I understand that massage practitioners do not diagnose illness, disease or any physical or mental disorder; nor do they prescribe medical treatment, pharmaceuticals or perform spinal thrust manipulations. I acknowledge that massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service. I have stated all of my child's medical conditions that I am aware of and will update the massage practitioner on any changes in health status. I understand that massage sessions are strictly therapeutic; inappropriate behavior will result in termination of the session.

_____ _____
Client or Parent's Signature (for clients under 18) **Date**

_____ _____
Practitioner's Signature **Date**