Stillpoint Holistic Studio LLC Ula Katsoulis LMT CST
Licensed Massage Therapist

Intake Form (Infants and Children)

CLIENT INFORMATION

Client Name:_____ Date:_____

Mother's Name_____ Father/Partner's_____

Address:_____ Cell Phone:_____

City, State, Zip _____ Email address:_____

Age:_____ Date of Birth:_____

Weight:_____Sex: M ( ) F ( ) Referred by:_____

Doctor's Name: _____Phone# :_____

Has the child ever had chiropractic, physical therapy, massage therapy or alternative therapies before?_____

SYMPTOMS & COMPLAINTS

What concerns have brought your child here?_____

Please list the child's major complaints, symptoms: be as specific as you can_____

How do you believe the it all began?_____
_____

What is the child's official diagnosis?_____

MEDICAL HISTORY

Please indicate the child's present medical status: illnesses, diseases, fractures, allergies, digestive problems_____

Any problems during pregnancy?_____

Please describe any problems at birth (include C-sections, VBAC, Suction/Forceps delivery, etc.):_____
_____

Indicate your child's past history of health (and dates) : illnesses, diseases, fractures, accidents, trauma (All trauma in the past-accidents, falls and injuries are important):_____

_____
__

List any surgery your child has undergone and dates:_____
_____
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List all medications (including supplements, herbs, over the counter drugs) your child is presently taking:_____
_____

List any diagnostic tests (X-ray, MRI, etc.) your child had and the results:_____

_____

CLIENT AGREEMENT AND RELEASE FROM LIABILITY

I,_____ (parent's name) agree to the following during and after the course of my child's therapy.

Please Initial:

1. At any time during a session, I have the right to stop the therapy if I feel uncomfortable_____.
2. I understand that the therapist is committed in assisting my child to heal her/himself in the shortest time possible._____.
3. I understand that there may be reactions to treatment, anticipated or unanticipated, and that it is my responsibility to discuss any symptoms of concern with the the therapist_____.
4. I understand that a 24 hour notice is required for cancellations/reschedules._____.