



Boerne Office - Mon, Tues, Wed, Fri
920 E. Blanco, #105, Boerne, TX 78006

San Antonio Office - THURSDAY ONLY
(Located in "The Park", Dr. Laura Cioppa)
16607 Blanco Rd, Ste 12105, San Antonio

Confidential Infant/Newborn/Child Intake Form

Name: _____ Date of Birth: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: () _____ Cell Phone: () _____

Mothers/Fathers Name: _____

Email address: _____ Would you like be to added to email? Y/N: _____

Referred By _____

Treatment time is valuable to all clients, so if you cannot keep your scheduled appointment, please call to reschedule so that someone else can utilize your appointment time.

***I hold your appointment just for you.
A "No Show" will be billed to you for the missed session.***

Please check any of the symptoms or physical problems you are currently or have previously experienced:

- | | | | |
|-------------------------------------|--|--|--------------------------------------|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Cancer | <input type="checkbox"/> Fussy / Non-Sleep | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Asberger's | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Headaches / Sinus | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Colic | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Stress |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Down's Syndrome | <input type="checkbox"/> Latching Issues | <input type="checkbox"/> Torticollis |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Epilepsy / Seizures | <input type="checkbox"/> Migraines | <input type="checkbox"/> Whiplash |

Other Concerns: _____

General & Medical Information:

YES NO

- ____ ____ Does the child see a Chiropractic Doctor? If so, whom?
____ ____ Is the child currently under any Doctor's care? If so, whom?
____ ____ Has the child had any traumatic accidents / broken bones?
____ ____ Has the child ever had surgery? When
____ ____ Is the child sensitive to touch/pressure in any area
____ ____ Has the child had immunizations? None, Up-to-date (Circle one)
____ ____ Is the child allergic to: Latex, Lanolin, analgesic balms, other? (Circle one)
____ ____ Birth Process: C-Section, Vaginal (Circle one)

Briefly describe child's diet _____

Briefly describe child's sleep habits _____

Briefly describe child's social behavior _____

Briefly describe your biggest challenge _____

Please list all medications/supplements child is taking: _____

Please take a moment and carefully read the following information and sign where indicated.

I (the client) understand that bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a allopathic physician, chiropractic physician, or other qualified medical specialist for any mental or physical ailment that I am aware of. I further understand that bodyworkers/massage therapists 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(s) given should be construed as such. I also understand that the therapist is trained in several soft-tissue modalities and we will decide together which modality is utilized. If I am uncomfortable for any reason, I will inform the therapist to terminate the session.

I understand everything discussed during the treatment will be held in total confidentiality between the practitioner and myself.

Parents Signature:

Date:

Practitioner:

Date: