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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:

☐ Allergies	☐ Cancer	☐ Fussy / Non-Sleep	☐ Sciatica
☐ Asberger's	☐ Cerebral Palsy	☐ Headaches / Sinus	☐ Scoliosis
☐ Asthma	☐ Colic	☐ Head Injury	☐ Stress
☐ ADD/ADHD	☐ Down's Syndrome	☐ Latching Issues	☐ Torticollis
☐ Autism	☐ Epilepsy / Seizures	☐ Migraines	☐ 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: