In Balance
Healing Massage &
Bodywork Center

Infant/Child
Medical History Form
PLEASE PRINT

Child Name: Gender: Date of Birth:

Parent / Guardian Name: Phone (H/C):

Address: Town / Zip:

Email:

Primary Physician: Date of Last Physical:

Medications / Natural Supplements:

How did you hear about us? Is this your child's first massage?

Reason for visit:

Has your child received any alternative treatments? Please specify.

Exercise habits? Relaxation Techniques?

Formula? Nursing? Or Both?

Does your child have a healthy diet?

How much water do they drink?

Vaccinated? Please specify.

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

Circle any of the following Conditions or Issues that your child currently has and/or previously had from the list below:

Allergies
Abdominal Distention
ADD / ADHD
Anemia
Anxiety
Apnea
Back / Neck
Behind on Developmental Milestones
Bladder
Bleeding / Bruising
Bow Legs
Bradycardia/ Tachycardia
Breathing
Broken Bones
Blood Pressure
Blood Clots / Phlebitis
Bowel
Brain
Cancer
Chest / Lung
Circulation
Cleft Lip / Cleft Palate
Clenching / Grinding
Cold Sweats
Constipation / Diarrhea
Concussions / Contusions
Depression
Dental
Diabetes
Digestion
Dizziness / Fainting
Dysplasia
Edema
Eye Issues / Glasses
Fatigue
Fractures / Dislocations
Gastrointestinal Feeding Tubes
Genitalia Development
Headaches
Hearing
Heart
Hemophilia
Hepatitis
Hernia
HIV / AIDS
Hydrocephalus
Inflammation
Jaundice
Joints
Kidney / Gallbladder
Mental / Emotional
Mold Exposure
Motor Tics / Twitching
Neurological
Pins / Screws
Psychiatric
Reflux
Respiratory
Scars / Wounds
Scoliosis
Seizures / Epilepsy
Sensitivities
Sinus
Skin Condition
Sleeping
Spine
Sprain / Muscle Strain
Stress / Excessive Worry
Stroke / TIA
Surgeries
Temperament / Mood
Thyroid
Tongue / Lip / Cheek Ties
Tumors
Ulcers
Weakness / Numbness
Verbal Development
Other: ____________________

Describe the circled above in detail. Make sure to include ANY accidents, births, dental procedures, falls, injuries, long-standing health matters, organ issues, syndromes, or anything pertinent to your child's health status from in utero to today. Use diagram on the back to indicate areas of injury and/or discomfort.

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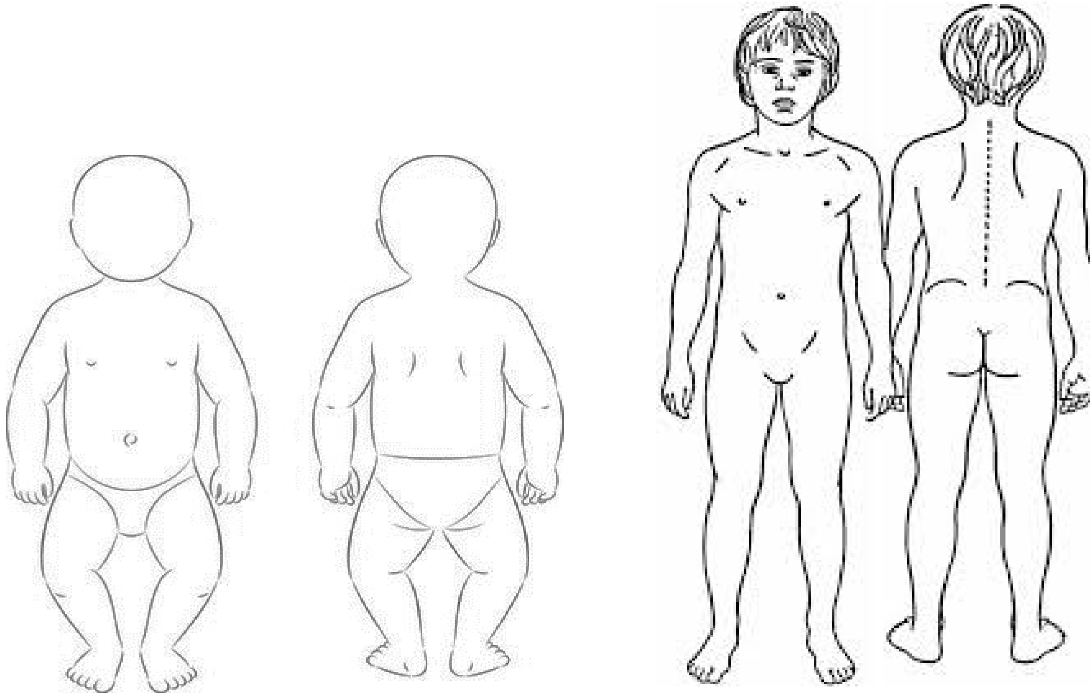
Please indicate on the drawings below where your child is feeling pain.



Client Agreement

By signing this form I certify that I am the parent or legal guardian of the child named on this form. I give permission for my minor child to receive treatment(s) at this facility. I understand that massage therapy is not a substitute for medical diagnosis or treatment, and that it is recommended I concurrently work with a Primary Caregiver for any condition my child may have. I am also aware that the massage therapist does not diagnose illness or disease and does not prescribe medications. I have informed the massage therapist of all known physical / medical conditions, and I will keep the massage therapist updated on any changes in my child's health status and/or medications.

If you must reschedule a 24 hour notice is appreciated.
Same day cancellations will be billed at half price. No shows will be billed at the full price.
Emergencies are understood.

My signature hereby verifies the above information is complete and true, and that I agree to the above terms.

Child's Name Printed: ______________________________

Parent / Guardian Name Printed: ______________________________

Signature of Parent / Guardian: ______________________________ Date: ______________

Notes for your Practitioner: