# PEDIATRIC MASSAGE INTAKE FORM

(For clients under the age of 18)

Massage Therapist Name: _____

Date: _____

**Client & Guardian Information**

Child's Name: _____

Age: _____ Date of Birth: _____

Gender: □ M □ F □ Other

Parent/Guardian Name: _____

Phone Number: _____

Email Address: _____

Emergency Contact (Name & Phone): _____

**Medical & Health History**

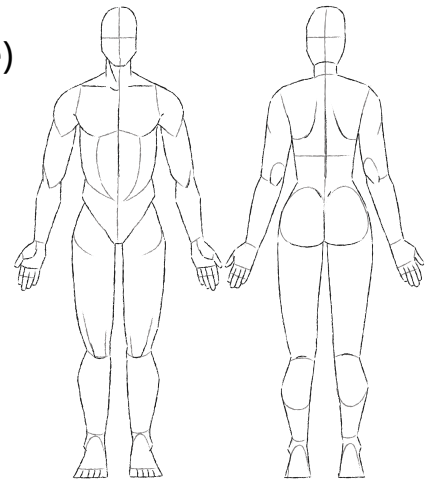
1. Primary Concern (Why are you seeking treatment?)
2. When did the issue begin? _____
3. Any medical diagnosis related to this issue?
   □ Yes □ No If yes, please describe:

4. Has your child received any of the following for this condition?
   □ Physical Therapy □ Occupational Therapy
   □ Chiropractic □ Massage □ Other: _____
   Were they helpful? _____
5. Has your child had imaging (X-rays, MRI, etc.)?
   □ Yes □ No If yes, what were the results?
6. Does your child take any medications?
   □ Yes □ No If yes, list: _____
7. Any recent surgeries, injuries, or hospitalizations?
   □ Yes □ No If yes, please describe:
8. Has your child ever been diagnosed with:
   □ Scoliosis □ Joint hypermobility □ Seizures
   □ Developmental delays □ Sensory processing disorder
   □ Heart condition □ Other: _____

**Functional & Behavioral Info**

1. What activities or movements cause pain or discomfort?

2. Where is the pain or discomfort located? (Please mark image)



3. Is the pain:
   □ Constant □ Comes and goes □ Only with activity
4. How does this affect daily activities (school, sleep, play, etc.)?

5. How does your child respond to touch?
   □ Enjoys it □ Neutral □ Sensitive to touch
6. Is your child comfortable being physically guided during movement?
   □ Yes □ No □ Unsure
7. What are your goals for this session or treatment series?

**Red Flag Screening (Confidential)**

Please check any that apply recently:

□ Unexplained weight loss □ Fevers or fatigue
□ Numbness/tingling in legs □ Bowel/bladder issues
□ Significant weakness □ Night pain or waking due to pain

If any of the above are checked, we may ask you to follow up with a healthcare provider before continuing treatment.

**Informed Consent**

I understand that massage therapy/bodywork is intended to promote relaxation, relieve muscular tension, and support movement function. It is not a substitute for medical care. I have disclosed all relevant medical information and understand the therapist's scope of practice.

I give permission for my child to receive massage therapy and movement-based techniques such as Kinetic Chain Release (KCR) and Total Motion Release (TMR). I understand that all sessions will be conducted professionally and respectfully, and I **must** be present during the **entire** session if my child is under the age of 16.

Parent/Guardian Signature: _____ Date: _____