Massages with Purpose and Skin Care

… Where Healing Begins

Client CHILD Information

CHILD'S Full Name: _____

Parent's E-mail: _____ Phone: _____

Date of Birth: _____ Age: _____ ☐ Female ☐ Male

Address: _____ City: _____ ZIP: _____

Emergency Contact / Phone: _____ Referred By: _____

Medical Information

Please check any of the following that apply to your child:

☐ PTSD	☐ Plagiocephaly (raised o side)	☐ Tongue/ Lip Tie	☐ Epilipsesy/ Seizures
☐ TMJ	☐ Brachycephaly (Flat in back)	☐ Blood Clots	☐ Chemo / Radiation
☐ Stroke	☐ High/Low Blood Pressure	☐ Heart Condition	☐ Chiari Malformation
☐ Sprains / Strains	☐ Neurological Disorders	☐ Brain Injury	☐ Anxiety/ Depression
☐ HIV / AIDS	☐ Kidney Dysfunction	☐ Headaches	☐ Infectious Disease
☐ Joint Pain	☐ Hemophilia / Bruise Easily	☐ Hydrocephalus	☐ Digestive Disorders

☐ Other Medical Conditions: _____

☐ Please List your GOALS FOR THIS SESSION and areas of tension, stress and / or pain you wish to be addressed: _____

☐ Has your child had a Professional Massage or CranioSacral Therapy before?

Your Child's Appointment Time has been reserved for them. Out of respect and consideration to your Therapist(s) and other customers scheduled after you, please plan accordingly by putting your appointment time on your calendar and be on time. A full 24-hour notice is expected for cancellations and reschedules to avoid a **$65 service charge**, as we are unable to fill your child's appointment in such short notice. Thank you for your understanding. _____

I understand that my child is receiving therapeutic services that Massages with Purpose offers, at my own risk. In the event that my child become injured either directly or indirectly as a result, in whole or in part, of the aforesaid therapeutic services offered, I hereby hold harmless and indemnify the therapist, Massages with Purpose, their principals, and agents from all claims and liability whatsoever. I have read and understand that Massages with Purpose complies with the HIPPA privacy requirements. _____

I have stated all conditions that I am aware of and this information is true and accurate to the best of my knowledge. I will inform my child's massage therapist if anything changes in my child's status. I understand that massage/bodywork I receive is for the purpose of stress reduction and the relief from muscular/structural tension, spasm or pain and to increase circulation, and is not a substitute for a medical examination or diagnosis and that I should take my child to their health care provider for those services. If I feel that my child is experiencing any pain or discomfort, I will immediately inform my child's massage therapist so that the pressure and/or methods can be adjusted to my child's comfort level. _____

I have carefully read the above and understand Massages with Purpose and Skin Care office policies. _____

CLIENT'S PARENT SIGNATURE _____ **DATE** _____

Massages with Purpose & Skin Care
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