BodySoulHealing LLC

Verena Giebels, LMT, CCST, MEd

Therapeutic Massage, Cranio-Sacral Therapy & Family Constellations

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Phone: 360.421.6296 Fax: 360.991.0017

Infant/Child Health History

Child's Name _____ Date of Birth _____

Parent(s) Name(s) _____

Phone Number(s) _____ Email Address_____

Address _____

Emergency Contact/Ph# _____ Pediatrician: _____

Who can I thank for referring you? _____

_____

Is the child currently seeing a doctor? N Y What is the diagnosis? _____

Was massage prescribed? N Y Does the child take any medication? N Y _____

What was the child's birth experience?_____

_____

Allergies? N Y _____ Skin conditions? N Y _____

Please list any previous injury, illness, surgery, trauma: (e.g. breaks, sprains, head injuries, sinus, tonsils, asthma, stomach, intestine, cognitive, behavioral, urogenital, infectious, inflammatory, cancer, ….) _____

_____

Describe the child's sleep _____

How is the child's digestion (incl. spitting, reflux, hick-ups) _____

_____

I realize that treatment is given for the wellbeing of client's body and mind. This includes stress reduction, relief from muscular tension, spasm, pain, treatment of injury, or for increasing circulation. I understand that massage therapists do not diagnose illness or any mental disorder, nor do they prescribe medical treatment. I acknowledge that massage is not a substitute for medical examination or diagnosis and it is recommended that I see a primary health care provider for that. I have stated all medical conditions that I am aware of and will update Verena in changes in my child's health. I understand these health records are confidential and authorize Verena Giebels, LMT, CCST, as my child's massage therapist, to contact my health care providers if necessary.

Parent/Custodian Signature _____ Date _____