Pediatric Massage Therapy and Infant Massage Instruction
Health History and Consent Form

Child's Name _____ Birthdate _____ Age _____

Parent(s) Name(s) _____ Main Phone _____

Email: _____

Street/City/Province _____ Postal Code _____
_____

Parent Occupation/Employer _____ Other Phone_____

How did you hear about our Infant Massage Program? _____

Why are you interested in learning infant massage? _____

Skeletal:	**Digestive:**	**Respiratory:**
- Aids in supporting good posture and balance - Reduces muscle tension that could lead to potential medical problems - Increases nutrient flow to bones **Muscular:** - Relieves muscle tension and spasm - Aids in removal of lactic acid & carbonic acid which build up after strenuous activity - Increases the flow of blood and nutrients to muscles - Can increase or decrease muscle tone depending upon amount of pressure - Can reduce or increase joint mobility depending upon amount of pressure	- May relieve constipation - May relieve gas - Reduces water retention Cleans the blood by toning the kidneys **Circulatory:** - Stimulates blood and lymph circulation - Helps strengthen the immune system - Releases toxins held in the body	- Improves breathing patterns - Helps reduce respiratory problems - Relieves tension in the chest allowing the lungs to expand more fully **Nervous:** - Relaxes and calms baby - Helps baby to sleep - Raises endorphin levels, promoting healing - Provides a safe and easy release from frustration and hyperactive behavior - The Vagus Nerve is stimulated influencing food absorption hormones (Insulin & Glycogen)

Massage therapy for an infant is not intended to replace other forms of healthcare. Used as a form of adjunctive healthcare, potential **benefits for the child include**:

Please mark your goals for your child's Pediatric Massage Program:

- ☐ Provide Comfort
- ☐ Promote relaxation
- ☐ Reduce stress
- ☐ Reduce pain
- ☐ Ease Depression
- ☐ Decrease anxiety
- ☐ Reduce muscle hyper tonicity
- ☐ Improve muscle tone (decrease hypo tonicity)
- ☐ Improve gastrointestinal functioning
- ☐ Improve joint mobility / range of motion
- ☐ Promote orientation of extremities toward midline
- ☐ Reduce chronic fatigue
- ☐ Improve pulmonary functions
- ☐ Decrease symptoms of atopic dermatitis
- ☐ Reduce lethargy
- ☐ Reduce colic / chronic abdominal pain
- ☐ Promote growth for baby born prematurely/child
- ☐ Improve self-soothing behavior
- ☐ Improve attentiveness and responsiveness
- ☐ Improve sleep patterns
- ☐ Decrease hypersensitivity to touch
- ☐ Encourage vocalization
- ☐ Enhance child's body awareness
- ☐ Promote parent-child bonding

Other Goals:

_____

_____

_____

Infant Massage is contraindicated if the child:

- Has High Fever/Temperature
- Has an acute infection, staph infection, illness or disease
- Has a skin disorder which may be contagious or cause inflammation
- Has open sores or lesions
- Has had recent immunization/vaccination (wait 48 – 72 hours)
- Has any life threatening medical condition
- Has an unhealed umbilical cord (tummy massage contraindicated)
- Has swollen lymph nodes
- Has blood clots or a blood condition
- Has diarrhea or other sickness

Common Precautions for Infant Massage include:

- ☐ Apnea
- ☐ Bradycardia
- ☐ Tachycardia
- ☐ Abdominal Distention
- ☐ Gastrointestinal or Jejunostomy feeding tubes
- ☐ Hydrocephalus
- ☐ Inflammations
- ☐ Edema/Swelling
- ☐ Dysplasia
- ☐ Hemophilia
- ☐ Jaundice
- ☐ Recent Surgery
- ☐ HIV/AIDS
- ☐ Tumors
- ☐ Cancer
- ☐ Seizure Disorders

Please indicate any of the high risk factors, complications that I should be aware of:

Is there other relevant information about the pregnancy, child birth, about you or the child, that I should know?

Health History

Birth History: ☐ Biological Child ☐ Adopted ☐ Foster Child

Postpartum complications? ☐ No ☐ Yes (describe): _____

Is your child currently under the care of a primary healthcare provider? ☐ Yes ☐ No

Name of healthcare provider: _____

Name of healthcare facility: _____

Location: _____ Phone: _____

My child is developing:

☐ like an average child for his/her age in all areas of development

☐ differently than an average child his/her age in any area of development.

Describe: _____

Please list medications, supplements or homeopathics the child is now taking:

Medication/Herb/Etc.	Reason	Started	Dosage

Please mark any of the following that your child now has or has had in the past. Identify the condition and location where applicable.

Now	Past	Condition	Now	Past	Condition
☐	☐	**Skin Conditions** (includes rashes, topical allergies, fungal infections, etc.) Type _____ Location _____	☐	☐	**Respiratory Conditions** (includes sinus, lung and bronchial conditions, etc.) Type _____ Location _____
☐	☐	**Muscle Conditions** (includes strains, tendonitis, spasms, cramps, etc.) Type _____ Location _____	☐	☐	**Circulatory Conditions** (includes heart, blood pressure, arteries and venous conditions, etc.) Type _____ Location _____
☐	☐	**Joint Conditions** (includes sprain, arthritis, degenerating joints, etc.) Type _____ Location _____	☐	☐	**Reproductive Conditions** (includes pregnancy, prostate, menstruation, etc.) Type _____ Location _____
☐	☐	**Nervous System Conditions** (includes numbness, tingling, nerve damage, shingles, etc.) Type _____ Location _____	☐	☐	**Digestive Conditions** (includes constipation, diarrhea, ulcers, etc.) Type _____ Location _____
☐	☐	**Infectious or Communicable Conditions** Type _____ Location _____	☐	☐	**Other Conditions** (includes any other health condition not previously listed) Type _____ Location _____

Other medical conditions, symptoms and/or further explanations: _____

_____

Please list any recent accidents, illnesses or surgeries (past 2 years -- or those that are still affecting your child): _____

_____

Please list any special dietary/nutritional considerations: (example: *gluten-free diet, allergies*)

_____

Therapeutic History

Has you child ever received massage or another bodywork therapy (professionally or by a parent's touch)? (example: *yoga therapy, cranial sacral therapy, bio-aquatic therapy*) ☐ Yes ☐ No

If yes, please explain: _____

Please list other complementary therapies or educational programs in which your child participates:

Therapy/Program	Reason	Started	Practitioner

Has your child been evaluated for or diagnosed with Sensory Integration Disorder? ☐ Yes ☐ No

If yes, please explain evaluation, diagnosis and/or therapy program: _____

_____

How does your child respond to touch/movement? Does your child:

	Never	Some	Often	Always	In the past	This is a problem
dislike being held or cuddled?						
seem irritated when touched?						
bang or hit head on purpose?						
seem overly aware of touch, texture or temperature?						
have an increased response to pain?						
Lack awareness of being touched?						
bite, chew or suck on blanket/pacifier/something to calm?						
frequently bump into or push people or items?						
have a strong need to touch objects and people?						
try to bite people?						
dislike being bounced, rocked or swung?						
seek out rough-housing play?						
have fear in space (i.e. on stairs, heights, etc.)?						
dislike being off balance?						

Personal History

Please describe your child's communication style:

☐ Verbal ☐ Word Approximations ☐ ASL ☐ PECs ☐ Augmentative Device ☐ Gestures None

Other: _____

How does your child deal with change? _____

_____

What types of methods does your child use to manage stressful situations (self-soothing techniques)?

_____

What makes your child: (And, how do you deal with it)

Happy? _____ _____

Sad? _____ _____

Angry? _____ _____

Stressed? _____ _____

Excited? _____ _____

Does your child attend school/preschool/daycare? ☐ Yes ☐ No

If yes, what are his/her teacher's name(s)? _____

What are the names/types of his/her pets? _____

What are the names of his/her siblings? _____

What are the names of his/her friends? _____

What types of exercise interests your child? _____

How does your child prefer to spend his/her time (hobbies/interests)? _____

_____

If a Legal Guardian of the child is not attending the classes/appointment, fill out this section:

I, _____, give this Non-Primary Caregiver, _____, my permission to attend class/appointment with, **and** to touch my infant/child, using the techniques taught in class.

Legal Guardian Signature _____ Date: _____

In case of emergency: Name: _____ **Phone:** _____

Name: _____ **Phone:** _____

Please read the following carefully:
This record of consent will be maintained confidentially in your family file and is required before any treatment can commence.

The integrity of each client and legal guardian is respected, thus:

- **All massage treatments, information, and records will be safeguarded and remain confidential.**
- **In the event that client information needs to be shared, written consent will be first acquired from the client/legal guardian.**
- **Privacy for undressing/ dressing will be assured. Removal of clothing to your comfort level is recommended.**
- **Proper draping will be provided to assure security and privacy. Only the body part being treated will be uncovered, leaving the remainder of the body fully covered at all times.**
- **Communicate with the therapist to ensure that they know your level of comfort during the entire session.**
- **Promptness is required for appointment times. In the event of lateness, the massage may be cut short. Fees will be maintained as per the schedule.**
- **Without a minimum of 12 hours notice for appointment cancellations, the full missed appointment fee will be added to your next invoice.**
- **The client/legal guardian may refuse, modify, or terminate treatment at any time, regardless of prior consent given.**
- **The therapist may refuse to treat any client or part of their body with just and reasonable cause.**
- **Consent can be revoked or modified at any time**

I understand that the massage involves pressure and kneading applied to various parts of the body. If my child experiences any pain or discomfort during the session, I (legal guardian) will immediately inform the therapist so that the pressure and/or strokes may be adjusted to a level of comfort. I understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment, and that it is recommended that I see a physician for any physical ailment that my child may have. I affirm that I have stated all of my child's known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my child's medical profile and understand that there shall be no liability on the massage therapists part should I fail to do so. I also understand that the Registered Massage Therapist reserves the right to refuse to perform massage on anyone whom he/she deems to have a condition for which massage is contraindicated.

I further understand that a massage therapist neither diagnoses nor prescribes for illness, disease, or any other medical, physical, or emotional disorder, nor performs any thrusting joint or spinal manipulations or adjustments.

I understand that I will be participating in infant massage therapy and infant massage lessons as a form of adjunct health care.
I have noted above all complications, risks, or conditions my child has experienced AND I have obtained my child's healthcare providers release.
I hereby release and hold harmless and defend the practitioner (Infant Massage Instructor) from any claims, liability, demands and causes of action from my and my child's participation in this therapy.

SUNSTONE HOLISTIC
Registered Massage Therapy

Ana Kordic RMT
Registered Massage Therapist
Certified Pediatric Massage Therapist
Certified Infant Massage Instructor

(647) 233-2569
akordic.rmt@gmail.com

I have read and understand the information contained in this form and consent to have my child treated by the therapist and intend to apply this consent to all of my future massage sessions at/with SUNSTONE REGISTERED MASSAGE / ANA KORDIC, RMT.

Print Name: _____ ***Date:*** _____

Signature: _____

Parent/Legal Guardian of _____

Instructor's Print Name: _____

Signature: _____ ***Date:*** _____