



***Massage Therapy***

***Kids***

**PERSONAL INFORMATION**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Gender: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Name of Parents/Guardians: \_\_\_\_\_

Relationship to child: \_\_\_\_\_ Do you have full custody of the patient: Y / N

Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_ May we contact you via e-mail? Y / N

Medical Doctor/Pediatrician: \_\_\_\_\_ Location: \_\_\_\_\_ Last Visit: \_\_\_\_\_

**How did you hear about us?**  Existing patient \_\_\_\_\_  Online  Doctor  Other: \_\_\_\_\_

**HEALTH CHALLENGES**

Please explain your child's health challenge: \_\_\_\_\_

When did it begin? \_\_\_\_\_

This challenge started:  Suddenly  Gradually  Unknown

Have you noticed any other symptoms associated with this challenge? \_\_\_\_\_

Have you seen anyone about this challenge? \_\_\_\_\_

**HEALTH CONDITIONS**

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

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Ear infections  | <input type="checkbox"/> Recurring Fevers | <input type="checkbox"/> Digestive problems            |
| <input type="checkbox"/> Asthma          | <input type="checkbox"/> Constipation     | <input type="checkbox"/> Bed wetting                   |
| <input type="checkbox"/> Allergies       | <input type="checkbox"/> Headaches        | <input type="checkbox"/> Seizures                      |
| <input type="checkbox"/> Colic           | <input type="checkbox"/> ADHD             | <input type="checkbox"/> Traumatic birth               |
| <input type="checkbox"/> Scoliosis       | <input type="checkbox"/> Car accident     | <input type="checkbox"/> Diarrhea                      |
| <input type="checkbox"/> Temper Tantrums | <input type="checkbox"/> Falls            | <input type="checkbox"/> Chronic colds                 |
| <input type="checkbox"/> Chicken pox     | <input type="checkbox"/> Rubella          | <input type="checkbox"/> Whooping cough                |
| <input type="checkbox"/> Rubeola/measles | <input type="checkbox"/> Mumps            | <input type="checkbox"/> Adverse vaccination reactions |
| <input type="checkbox"/> Eczema          | <input type="checkbox"/> Other _____      |  |

Please list any health conditions in your family history

\_\_\_\_\_  
 \_\_\_\_\_

**PRE-NATAL AND CHILDHOOD HISTORY**

Complications during pregnancy: \_\_\_\_\_

Were ultrasounds used during pregnancy? Y / N How many? \_\_\_\_\_

Please list any medications during pregnancy? \_\_\_\_\_

Cigarette/Alcohol use during pregnancy? Y / N How many? \_\_\_\_\_

Location of Birth: \_\_\_\_\_

Birth intervention:  Natural  C-Section  Forceps  Vacuum extraction  Other \_\_\_\_\_

Delivery complications: \_\_\_\_\_

Birth Weight: \_\_\_\_\_ Birth Length: \_\_\_\_\_ APGAR score: \_\_\_\_\_

Breast Fed – If yes, how long? \_\_\_\_\_  Formula – If yes, how long? \_\_\_\_\_

Introduced solids at \_\_\_\_\_ months. Introduced to cow's milk at \_\_\_\_\_ months.

Have you noticed any adverse reactions to certain foods? \_\_\_\_\_

*Please indicate the age able to:*

Respond to sound \_\_\_\_\_ Respond to visual stimuli \_\_\_\_\_ Crawl \_\_\_\_\_ Stand \_\_\_\_\_

Hold head up \_\_\_\_\_ Walk alone \_\_\_\_\_ Sit \_\_\_\_\_

Has there been any surgeries? Please explain: \_\_\_\_\_

Number of doses of antibiotics your child has taken: \_\_\_\_\_

Prescription medication your child has taken: \_\_\_\_\_

Vaccination History: \_\_\_\_\_

**INFORMED CONSENT TO MASSAGE THERAPY TREATMENT**

I understand that the Registered Massage Therapist is providing services within his or her scope of practice as defined by the College of Massage Therapists of Ontario. I hereby request and consent to the service of massage therapy treatment and other massage procedures, including various modes of remedial exercise and hydrotherapy.

I am informed that, as in all health care, in the practice of massage therapy there are some very slight risks to treatment, including, but not limited to, muscle tenderness, light-headedness, or dizziness.

I understand that the therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that massage therapy is not a substitute for medical examination.

I have completed my medical history form and have disclosed to the therapist all of those medical conditions affecting me. It is my responsibility to keep the massage therapist updated on my medical history.

I have read the above consent. I agree to this consent form to cover the entire course of the treatment for my present condition and for any future condition(s) for which I seek treatment. I

understand that at any time I may withdraw my consent, and treatment will be stopped. I understand that failure to provide 24 hours notice prior to cancelling an appointment may result in a charge of a \$40.00 missed appointment fee.

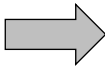
*I understand that because of the nature of HealthTweak Wellness Group, patient files and information contained in files may be shared among practitioners for the mutual benefit of patient treatment. All information will remain confidential. I understand that written consent must be obtained for a practitioner to remove/transfer file information outside of HealthTweak Wellness Group.*

**PERSONAL HEALTH INFORMATION CONSENT FORM**

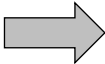
I understand that HealthTweak is my health information custodian. I consent to the collection, use and disclosure of my personal health information for treatment and other health care reasons. HealthTweak is a multidisciplinary clinic, and therefore treatment notes may be shared between practitioners to best treat the patient.

I understand that to provide me with Massage Therapy, Chiropractic, Physiotherapy, Naturopathic Medicine or any other health care services, HealthTweak will collect personal information about me (e.g. birth date, home contact information, health history, etc.)

I understand that HealthTweak will only collect, use, or disclose my personal health information with my express or implied consent; unless a collection, use, or disclosure without consent is permitted or required by law.

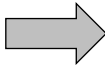


I give permission to HealthTweak to contact your primary healthcare provider such as my medical doctor, nurse practitioner ect.



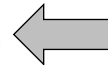
Name: \_\_\_\_\_

Name of Witness: \_\_\_\_\_



Signature: \_\_\_\_\_

Date: \_\_\_\_\_



**Thank you for completing this form.**