Massage Therapy

Kids

HealthTweak Patient # _____ ☐ Dr. V. Suprunov, BSc, DC

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:

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

Please list any health conditions in your family history

_____

_____

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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 Health*Tweak* 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. Health*Tweak* 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, Health*Tweak* will collect personal information about me (e.g. birth date, home contact information, health history, etc.)

I understand that Health*Tweak* 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.