Bloom into Balance LLC

Craniosacral Therapy, Myofascial Unwinding and Reiki

Pediatric Client information

**Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Alternative Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent’s Name and self-identifying role: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent’s Name and self-identifying role: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Siblings:**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age: \_\_\_\_\_\_\_ Sex:\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age: \_\_\_\_\_\_\_ Sex:\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age: \_\_\_\_\_\_\_ Sex:\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age: \_\_\_\_\_\_\_ Sex:\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Telephone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Who can I thank for referring you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What brings you to seek Craniosacral Therapy for your child? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**FAMILY MEDICAL HISTORY**

Please indicate if any blood relatives to the child have had any of the following by using the notations:

M = Mother MGM = Maternal Grandmother PGM = Paternal Grandmother

F = Father MGF = Maternal Grandfather PGF = Paternal Grandfather

S = Sibling

\_\_\_\_ Allergy, Asthma or Eczema

\_\_\_\_ Cancer

\_\_\_\_ Diabetes or Low Blood Sugar

\_\_\_\_ Heart Trouble

\_\_\_\_ High Blood Pressure/Stroke

\_\_\_\_ Kidney Disease

\_\_\_\_ Liver Disease

\_\_\_\_ Developmental Disability

\_\_\_\_ Mental Illness

\_\_\_\_ Scoliosis

\_\_\_\_ Ulcer

\_\_\_\_ Seizure Disorder

\_\_\_\_ Vaccine Reaction

\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PREGNANCY**

Please check any areas that applied to the client’s mother during her pregnancy:

* Prenatal Classes
* Premature Contractions
* Complications
* Back Pain
* Bleeding
* Other Pain
* Hospitalization
* Smoking
* Alcohol
* Recreational Drugs
* Excessive Weight Loss
* Excessive Weight Gain
* Medications
* Toxic Exposures
* Caffeine: Cola
* Caffeine: Coffee
* Caffeine: Tea
* Caffeine: Chocolate
* Caffeine: Other
* Immunizations/Flu Shot
* Allergic Reactions
* Mental Trauma
* Vitamins/Minerals
* Chiropractic Care
* Any Diagnosed Illnesses
* Attitude – Mostly Happy
* Attitude – Mostly Depressed
* Physical Injury

**BIRTHING TIME AND BIRTH (LABOR AND DELIVERY)**

Please check any items(s) that apply:

* Home Birth
* Hospital Birth
* Induction
* Caesarean
* Complications
* Continuous Fetal Monitor Used
* Intermittent Monitoring Used
* Premature Delivery
* Medications
* Vacuum Extraction
* Forceps
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check any item(s) that applied to the baby/child at birth:

* Difficulty Breathing
* Choking
* Crying
* Sleeping Excessively
* Difficulty Waking/Lethargic
* Jaundice
* Coloring
* Difficulty latching on
* Difficulty nursing
* Medications
* Surgery
* Circumcision
* Formula Feeding
* Vitamin K
* Erythromycin
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**BIRTH INFORMATION**

Length of Pregnancy:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth weight: ­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Birth length:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Head Circumference: \_\_\_\_\_\_\_\_\_\_\_\_\_

APGAR Score at 1 minute: ­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_ At 5 minutes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NUTRITION**

Please indicate if the baby/child has received any of the following:

* Human (breast/chest) Milk
* Commercial Formula
* Cow’s Milk
* Goat’s Milk
* Other Milk: \_\_\_\_\_\_\_\_\_\_\_\_
* Juice: Fruit
* Juice: Vegetable
* Solid Foods
* Vegetarian Diet
* Organic Meats
* Vitamins
* Sweets/Candy
* Medications
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**VACCINATIONS/IMMUNIZATIONS**

Please list if the baby/child has had any vaccination (immunizations) reactions (minimal response to severe):

Date Type Response

|  |  |  |
| --- | --- | --- |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Has the baby/child traveled abroad? Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ILLNESSES**

Please list any illnesses or previously diagnosed conditions:

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

**HEALTH CARE PROVIDERS**

Pediatrician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of last exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chiropractor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Homeopath: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupational Therapist: ­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**GENERAL SYSTEM REVIEW**

Please check any that apply to baby/child:

* Had any allergies, eczema, hay fever, hives, asthma or drug reactions?
* Been unconscious or had a convulsion?
* Had problems with the eyes, including vision?
* Been cyanotic (turned blue)?
* Had recurring problems with vomiting, diarrhea, constipation or stomach pain?
* Had problems passing stools?
* Had unusual stools in appearance or smell?
* Had problems passing urine?
* Had unusual urine in appearance or smell?
* Complain of any extremity or back pain?
* Do you notice a limp or unusual gait pattern?
* Tolerated exercise?
* Had any other problems?

**RELEASE**

Please take a moment to carefully read the following information and sign where indicated.

If your child has a specific medical condition or specific symptoms, massage/craniosacral therapy/Reiki may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

I understand that the massage/craniosacral therapy/Reiki that my child receives is provided for the basic purpose of relaxation and relief of muscular/connective tissue tension. If I notice that my child is experiencing any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my child’s level of comfort. I further understand that massage/craniosacral therapy/Reiki should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailments that I am aware of. I understand that massage/craniosacral therapy/Reiki practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/craniosacral therapy/Reiki should not be performed under certain medical conditions, I affirm that I have stated all my child’s known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my child’s medical profile and understand that there shall be no liability on the practitioner’s part should I forget to do so.

\*COVID-19 addendum: I certify that I will not come to any appointments if I or an immediate member of my household are exhibiting COVID-19 symptoms and that I will alert the practitioner before our appointment as soon as possible. I understand that I will not be charged for my appointment but that I will make every attempt to reschedule/cancel my appointment before the 24-hour window of my appointment time. In addition, I understand that the practitioner will make every attempt to keep a clean, safe office space and will not see patients if she or an immediate member of her household is ill and that she will alert me of the cancelled appointment as soon as possible. I release the practitioner (Laura Hanstad) of any and all liability if I become ill after an appointment.

|  |
| --- |
| **I agree to comply with the cancellation policy,**  **which requires 24 hours notice for any rescheduled or cancelled appointment.**  **If it is not possible to provide 24 hours notice, I will be responsible to pay the posted fee.** |

Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_