WELLNESS FROM WITHIN

Pediatric Intake Form

Last Name: _____ First Name: _____
Parent(s): Mother_____Father_____Birthdate: _____/_____/___ Sex: M / F
Mailing Address: _____ City: _____
State: _____ Zip Code: _____ Home Phone: _____
Emergency Contact: _____Relationship to Patient: _____
Contact's Phone Number: _____ Contact's Email:_____
Referred by: _____

Current Health Care Team:
Patient's Pediatrician: _____
Specialist Physician: _____ Specialty: _____
Specialist Physician: _____ Specialty: _____
Other Health Care Team Members (Ex: massage therapist, nutritionist, acupuncturist, etc.):
Practitioner Name: _____
Practitioner Name: _____

Please list current health concerns, time of onset, and current treatment:

Condition	Onset/Duration	Treatment (if any):
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PAST MEDICAL HISTORY
Pregnancy:
Duration of pregnancy:_____Any complications with pregnancy? Y N
Please explain:_____
Type of birth delivery: cesarean section / vaginal Birth Weight: ____ lb. Height ____ in.
Any complications with delivery? Y N _____
Newborn:
Any significant health concerns as newborn? (eg. anemia, jaundice, respiratory difficulty, infection) _____
To date, please list history of all major illnesses, hospitalizations, surgical procedures including dates._____
History of head injury or other major injury? Y N _____
Has this child ever been unconscious or had seizures? Y N
Immunizations/vaccinations: Y N Flu Shot Y N
Date of last Physical/Wellness Exam: _____
Please list any Life Threatening Allergies:_____
Other Allergies, sensitivities, or intolerances (eg. food, medication, environmental, chemical, etc.): _____

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FAMILY HISTORY:

Place appropriate letter(s) in blank if someone in the child's family has/had any of the following. (F=Father, M=Mother, S=Sibling, G=Grandparent)

___ Alcoholism	___ Crohn's Disease	___ Neurological Disorder
___ Allergies/Eczema	___ Diabetes	___ Obesity
___ Asthma	___ Drug Abuse	___ Heart Disease
___ Autoimmune Disorders	___ Epilepsy/Seizure	___ Thyroid Disorder
___ Cancer, specify type(s): _____		___ Headaches/Migraines

Any other condition:_____

LIFESTYLE:

Please select the following that apply to this child (write N/A if does not apply)

___ Stays at home ___ Involved in after-school activities (Ex: _____)

___ Daycare (___ days/week) ___ Socializes well with other children

___ School (grade level_____) ___ Holds attention while working on a task

Describe the child's family situation: (number of siblings, parental involvement in child's life, etc):

_____

_____

Favorite Activities: _____

Fears and Anxieties: _____

DIET:

Please check any of following: ___Mixed Diet (animal/vegetable) ___Vegetarian ___ Organic

Please list any Food Restrictions (eg. dairy, gluten, soy, etc.)_____

_____

I have completed this form to the best of my ability in reference to this child's health history. I have stated all known health conditions for this child and will alert the practitioner of any new condition as it arises.

Signature: _____Date:_____

Relationship to Patient: _____

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CONSENT FOR CARE:

You have the right to seek a second opinion or to end the evaluation/treatment at any time. You are entitled to information about the methods and techniques used in the evaluation/treatment. You may also ask the therapist for information about her training and credentials. I, _____, understand that Craniosacral Therapy is not a substitute for standard medical care. I will alert the practitioner to any changes in my child's health status, including medication changes. It is my choice to receive Craniosacral Therapy for my child with an understanding of the risks and benefits, and I give my consent for treatment of my minor child. I understand that there is no stated guarantee for effectiveness of treatment.

Signature_____Date_____