Beautiful Beginnings
INFANT MASSAGE CLASS

# Medical Intake Form

Child's Name: _____ Date of birth: _____

Parents Name: _____ Cell Phone: _____

Address: _____ Home Phone: _____

City _____ State _____ Zip: _____

Email _____ Who may we thank for your referral? _____

Is your child under the care of a physician for any medical condition other than well baby care?

☐ Yes ☐ No If yes, please list physician name, address and phone _____

_____

_____

Does your child have any of the following medical conditions?

| | | | | | |
|---|---|---|---|---|---|
| Circulatory | ☐ Yes | ☐ No | Respiratory | ☐ Yes | ☐ No |
| Cardiac | ☐ Yes | ☐ No | Bradycardia | ☐ Yes | ☐ No |
| Tachycardia | ☐ Yes | ☐ No | Abdominal distention | ☐ Yes | ☐ No |
| Gastrointestinal | ☐ Yes | ☐ No | Hydrocephalus | ☐ Yes | ☐ No |
| Hemophilia | ☐ Yes | ☐ No | Premature birth | ☐ Yes | ☐ No |
| Jaundice | ☐ Yes | ☐ No | Recent surgeries | ☐ Yes | ☐ No |
| HIV/AIDS | ☐ Yes | ☐ No | Tumors | ☐ Yes | ☐ No |
| Cancer | ☐ Yes | ☐ No | Hernia | ☐ Yes | ☐ No |
| Seizure disorders | ☐ Yes | ☐ No | Shunt | ☐ Yes | ☐ No |

Gastrointestinal or Jejunostomy feeding tubes ☐ Yes ☐ No

If you answered yes to any of the above, please explain in detail: _____

_____

_____

Did you experience any problems during pregnancy, labor, or childbirth? _____

_____

Is there any other relevant information about the pregnancy, childbirth, you or your child that we should be aware of? _____

_____

_____

_____

I _____ (print name) understand that I will be participating in infant massage therapy lessons.

I have noted all complications, risks or conditions my child has experienced. It is my responsibility to keep the instructor informed in writing of any changes to my child's medical history. I understand that I will be receiving infant massage therapy lessons as a form of adjunctive health care only and that this is not a substitute for other healthcare provided by a medical doctor, or other licensed provider. I hereby release and hold harmless the practitioner (infant massage instructor) and Beautiful Beginnings Infant Massage LLC from any claims, liability, demands and causes of action from my and my child's participation in this therapy.

Print Name_____ Date_____

Signature_____ (parent or legal guardian)