HOLISTIC INSTITUTE OF
Health & Fertility

SOUTH 143, 14919 Deer Ridge Dr. SE, Calgary T2J 7C4
Tel: 403.455.8029 **Email:** south@holisticinstitute.ca

NORTH 150, 4411 16th ave NW Calgary, AB T3B 0M3
Tel: 403.984.3970 **Email**: north@holisticinstitute.ca

MASSAGE / CRANIOSACRAL THERAPY

Pediatric (age 0-12)

Patient Information

Date: ______________________ Child's Name: (last) ______________________ (first) ________________________

Parent 1 Name: ______________________________ Parent 2 Name: ____________________________________

Address: ____Postal Code__________________

Phone: (1) _______________________ (2) _________________________ Email ___________________________

Child's Age: __________ Weight: _____________ Height: _______________

Birth date: _____________________________ Birth Place: ____

School/daycare: ________________________ Family MD/Pediatrician: ____________________________________

Referred by: ____

Current Health Condition

Purpose of appointment/current complaint:

____

When/how did the current complaint occur: ____

Is this complaint: (circle): new/recurring

Did it come on (circle): suddenly/gradually/comes & goes

Did a fall, injury or trauma contribute to the current complaint: ____

Is your child presently taking medication/or under any other medical care: ________________________________

For what conditions: ____

Past Health History

<u>Birth History:</u>

Length of Pregnancy: full term (weeks)__________ / early (weeks): _________/late (weeks): ________________

Any issues during pregnancy for mom/baby: (position of baby, blood pressure etc.) __________________________

____

Type of delivery: (circle) Normal vaginal/ Breech/ Cesarean Invasive procedures: Epidural/ Forceps/ Vacuum

Length of labour: _________________________ Normal/difficult

Birth Weight: _____________ Birth Length: __________________ Congenital anomalies: ______________________

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Infant History:

Feeding: (circle) Breast/ Bottle/ Formula Latching well: Y/N Breast preference: Y/N/right/left

Sleep Quality: good/fair/poor Average hours/night ____________ Average hours in a row: _______________

Trouble falling asleep: (circle) always/occasional/never

General Health History:

Any known Health conditions/Allergies:____

Illness/Injuries: ____

Hospitalizations/Surgeries/ Stitches/ X-rays____

Previous Massage/ Craniosacral Treatment: ____

Date: ____

Vaccination history: ____

Last doctor's appointment: _________________________Concerns: ____________________________________

Treatment for any health conditions in the past year: ____

Lifestyle: please circle any that apply to your child

Activities: Basketball/ Dance/ Running/ Gymnastics/ Skiing/ Swimming/ Hockey/ Soccer /

Other: ____

Computer/desk time: _______hours/day

Diet: (circle) Good/fair/poor

Sleep Quality: (circle) Good/fair/poor

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Please **check** any of the following conditions that are **currently** a problem; and underline any that were a problem in the past:

MUSCLE & JOINT
sore muscles
sore joints
growing pains
muscle cramps
muscle jerking
back problems
neck problems
painful tailbone
pain between shoulders
spinal curvature
arthritis
difficulty chewing
clicking in jaw
general stiffness
walking problems
feet turn in/out
coordination problems
headaches
pain in ankles/knees/hips

GENERAL
fatigue
allergies
difficulty sleeping
dizziness/fainting
earaches/infections
nose bleeds
sore throat/ frequent colds/flu
asthma
chronic cough
enlarged glands
loss of weight
poor exercise/appetite
nervousness
depression/confusion
Vision/dental/hearing problems
hyperactivity
behavioral problems
Epilepsy/seizures
rheumatic fever
stomach aches

INFANCY
Colic
tilting head to one side
difficulty nursing
preferred side nursing
slow weight gain
fussing in specific positions
Screaming/crying

ORGANS
bedwetting
constipation/diarrhea
anemia
Thyroid issues
vomiting
skin eruptions/eczema

OTHER CONCERNS

I have rights for this child and by signing below authorize Massage/ Craniosacral care for him/her.

Signature: ______________________________ Date: ______________________________

Print name: ______________________________ *please also see informed consent

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HIHF CLINIC CANCELLATION POLICY

We understand at the Holistic Institute of Health and Fertility (HIHF) that unplanned events can come up and you may need to cancel an appointment. If that happens, we respectfully ask for scheduled appointments to be cancelled with at least 24 hours notice.

We want to be available for your needs and the needs of all our clients. When a client does not show up for a scheduled appointment, another client loses an opportunity to be seen. In the event of a missed appointment or an appointment cancelled within less than 24 hours' notice, you will be charged the **FULL FEE.**

MasterCard, Visa and American Express are accepted at the clinic. Your credit card number will be kept on file to book/hold your appointment. Your credit card will only be charged should an appointment be missed without notifying the HIHF clinic.

Please indicate your acceptance of this policy by signing below. You are a valued patient, thank you for your understanding and cooperation.

Signature: ______________________ Printed Name: ______________________

Date: ______________________

Signature of Parent or Guardian if the Patient is under 18 years of age: ______________________

HIHF CLINIC WAIVER

I understand that I should be evaluated by a physician for the condition I am requesting consultation. The diagnosis and treatment plan I will be given by the Holistic Institute of Health and Fertility (HIHF) is based on traditional Chinese medicine, and/or therapeutic massage, and/or yoga principles only and does not constitute a Western Medical diagnosis. I understand that I am not to rely on these therapeutic diagnosis and treatments as my sole remedy for the treatment I am seeking.

I understand there may be some minor risks associated with these therapies including but not limited to slight bleeding, bruising, and mild dizziness. I understand clinic staff may review my records but all information will be kept confidential and will not be released without my written consent.

If no substantial improvement is made in the condition for which I am seeking consultation, I am to seek advice from a Western Medical doctor. Further, if I am concurrently undergoing Western Medical treatments, it is my responsibility to advise my physician of any of these therapies and/or herbal supplements I am concurrently taking.

I assume all risks and responsibilities for myself and release HIHF clinic and its agents from any injury or liability that may occur during a treatment session.

Please sign and date below to indicate that you have read and understood this form.

Signature: ______________________ Printed Name: ______________________

Date: ______________________

Signature of Parent or Guardian if the Patient is under 18 years of age: ______________________