The Roots of Health

CranioSacral Therapy, Therapeutic Massage, Reiki
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PATIENT INFORMATION

Patient Name	
Date of Birth	
Age	
Gender	
Parent / Guardian Name	
Address	
City, State, Zip	
Home Phone	
Cell Phone (*use for automated appointment reminders Y/N*)	
Email Address (*use for automated appointment reminders Y/N*)	
Primary Physician Name and Phone	
Daytime Caregivers Name	
Language(s) Spoken In Home	
Language(s) Spoken By Caregivers	

Unless specifically noted otherwise, provision of contact information assumes permission for The Roots of Health to contact you with questions or information related to the client's therapy, general information, or promotional offers.

BACKGROUND INFORMATION

Describe your primary concern(s) regarding your child?	
At what age did you first become concerned?	

PRENATAL / BIRTH HISTORY

History of pregnancy (i.e. medication, health of mother, complications):			
Maternal Age			
Number of previous pregnancies			
Number of children			
Ages of children			
Length of pregnancy	Full Term		Weeks Gestation
	Premature		Weeks Gestation
Type of delivery	Vaginal	C-Section	Breech
Note complications of labor / delivery, including medications			
Birth weight			
Length of hospital stay			
Did / does your child have difficulty…	Sucking?	Yes	No
	Swallowing	Yes	No
	Chewing?	Yes	No
	Changing to solids?	Yes	No

DEVELOPMENTAL HISTORY

Present level of activity	Active	Typical	Low Arousal
Developmental milestones (give approximate age	Sat alone	Crawling	Walking
	Running	Babbling	First Words
	Sentences	Dressing Self	Holds Bottle

	Uses Utensils	Cup Drinking	Uses Straw
	Finger Feeds	Hand Dominance	
Behavioral concerns			

SPEECH-LANGUAGE DEVELOPMENTAL HISTORY

Was your infant…	A quiet baby?	Yes	No
	A frequent crier?	Yes	No
	Irritable?	Yes	No
	Visually alert / attentive?	Yes	No
	Auditorily alert / attentive?	Yes	No
At what age did your child…	Babble?		
	Understand speech sounds?		
	Imitate speech sounds?		
	Say first words?		
	Use two or more words in a phrase?		
Did your child begin to babble then stop?	Yes, at age _	No	
At present, does your child have:	Understandable speech?	Yes	No
	A loud voice?	Yes	No
	A monotone voice?	Yes	No
	A hoarse voice?	Yes	No
Does your child:	Respond to sound?	Yes	No
	Respond to loud sounds only?	Yes	No
	Seem to willingly ignore sounds?	Yes	No

MEDICAL HISTORY

List past/present medications	
List significant illnesses and infections (give approximate dates):	
List surgeries and hospitalizations (give approximate dates):	
List any allergies (food and nonfood)	
Did / does your child suffer from frequent ear infections? If yes, list number since birth.	

EDUCATIONAL BACKGROUND

Name of School	
Grade	
School Address	
School City, State, Zip	
School Phone	
Teacher's Name	
Academic Concerns	

FUNCTIONAL STATUS

Self-Care	
Visual Perceptual	
Fine Motor	
Gross Motor	
Social / Emotional	
Cognition	
Language	
Attention / Concentration	

SENSORIMOTOR HISTORY

The following questions are utilized as a tool in order to compile a more complete picture of your child from early infancy to his/her present developmental stage. Some of these questions may refer to children who are older than your own. Kindly cross out the verb tense that does not apply. Circle the choice that applies: (Yes, No). Add narrative information if necessary. Thank you for your cooperation.

Please think of the various stages of your child's development, taking into considering behaviors as you answer the questions below. What do you think of as being different from other children you know? Are there times when his/her behavior is difficult to cope within the family unit?

CHILD'S BIRTH

Was or did child...	Full term?	Yes	No
	Premature?	Yes	No
	Cesarean section?	Yes	No
	Breech (feet first)?	Yes	No
	Cord around neck?	Yes	No
	Require forceps?	Yes	No
	Have sufficient oxygen?	Yes	No
	Require ICU hospitalization?	Yes	No
	If yes, how long?		
	Have respiratory problems?	Yes	No
	Need a respirator?	Yes	No
	If yes, how long?		
	Small for gestational age?	Yes	No
	Have a heart defect?	Yes	No
	Have jaundice?	Yes	No
	If yes, how long?		
	Have congenital abnormalities?	Yes	No
	Have seizures?	Yes	No
	Have infections?	Yes	No
	If yes, type of infections?		
	Have surgery as newborn?	Yes	No
	Have feeding problems as a newborn?	Yes	No
Comments:			

TACTILE (TOUCH)

Does child…	Dislike being held or cuddled?	Yes	No
	Constantly touch objects or intrude in others personal space?	Yes	No
	Seems easily irritated or enraged?	Yes	No
	Have a strong need to touch objects and people?	Yes	No
	Pinch, bite or otherwise hurt him/herself or others?	Yes	No
	Frequently bumps or pushes others?	Yes	No
	Doesn't cry when seriously hurt?	Yes	No
	Dislikes the feeling of fuzzy/furry clothing/textures?	Yes	No
	Over or under dresses for the temperature?	Yes	No
	Seem overly sensitive to rough food textures?	Yes	No
	Dislike having hair washed/ cut or nails cut?	Yes	No
	Dislike the feeling of sand, mud, and clay on hands/feet?	Yes	No
	Often seems unaware of minor cuts, bruises, etc?	Yes	No
	Seem unaware of food/liquid left on lips?	Yes	No
	Tell what is in his/her hand without looking?	Yes	No
Comments:			

VESTIBULAR (MOVEMENT)

Does child…	Like rough housing, jumping, crashing games?	Yes	No
	Like being tossed in the air?	Yes	No
	Like fast spinning carnival rides?	Yes	No
	Play on swings or slides?	Yes	No
	Spin or whirls more than other children?	Yes	No
	Get carsick easily?	Yes	No
	Get nauseous and/or vomit easily?	Yes	No
	Have fear in space (stairs, heights)?	Yes	No

	Lose balance easily?	Yes	No
	Walks on toe (not flat feet)?	Yes	No
	Like being upside down (somersaults, hanging from legs?	Yes	No
	Prefer to be sedentary (on computer/ TV) than play outside?	Yes	No
Comments:			

VISUAL

Does child…	Have a diagnosed vision problem?	Yes	No
	Have trouble tracking objects with eyes?	Yes	No
	Avoid eye contact with others?	Yes	No
	Have trouble copying words from the board?	Yes	No
	Dislike having eyes covered?	Yes	No
	Make reversals when copying or reading?	Yes	No
	Have trouble discriminating shapes, colors correctly?	Yes	No
	Squint often (when reading or outside in sunlight)?	Yes	No
Comments:			

TASTE & SMELL

Does child…	Chew on non-food items (pencils, shirt, hair)?	Yes	No
	Demonstrate being an EXTREMELY picky eater?	Yes	No
	Have trouble eating different textured foods?	Yes	No
	Sensitive or insensitive to noxious smells/tastes?	Yes	No
	Taste or smell objects when playing with them?	Yes	No
	Prefer spicy, sour bitter food flavors?	Yes	No

AUDITORY (SOUND)

Does child…	Have a diagnosed hearing problem?	Yes	No
	Have PE tubes in his/her ears?	Yes	No
	Have frequent ear infections?	Yes	No
	Show difficulty/bother by loud sounds (school bells, sirens)?	Yes	No
	Respond negatively to unexpected noises?	Yes	No
	Show bother by back round sounds such as refrigerator, fluorescent light bulbs, fans, when trying to concentrate?	Yes	No
	Fail to listen, or pay attention to what is said to him/her?	Yes	No
	Like to play or make music at loud volumes?	Yes	No
	Like to sing and/or dance to music?	Yes	No
	Have difficultly if 2 or 3 steps instructions are given at once?	Yes	No
	Talk excessively/ not wait their turn?	Yes	No
	Have a delay in speech development?	Yes	No
Comments			

MUSCLE TONE

Does child…	Big for his/her age?	Yes	No
	Have any diagnosed muscle problems?	Yes	No

	Have flat feet?	Yes	No
	Slouch when sitting on floor/chair?	Yes	No
	Get tired easily playing or writing?	Yes	No
	Seem generally weak compared to other kids?	Yes	No
	Keep mouth open when breathing?	Yes	No
Comments			

COORDINATION

Does child…	Sit, stand or walk late?	Yes	No
	Was creeping and crawling phase unusually prolonged?	Yes	No
	Was creeping and crawling phase almost entirely omitted?	Yes	No
	Have difficulty with sequential tasks; dressing, buttoning, zipping?	Yes	No
	Have difficulty playing on playground equipment?	Yes	No
	Have difficulty learning to hold a pencil or crayon in a 3-point position?	Yes	No
	Have poor ball skills for P.E. type activities?	Yes	No
	Seem clumsy, awkward?	Yes	No
	Bump into furniture, people a lot?	Yes	No
	Consistently use a dominant hand?	Yes	No
	If yes, which hand?	Right	Left
	Have poor handwriting?	Yes	No
	Have trouble using both hands together easily (opening milk carton, water bottle etc.)?	Yes	No
	Enjoy sports, gym, etc?	Yes	No
	Able to ride a bike (tricycle, big wheel)?	Yes	No
	Able to tie shoelaces?	Yes	No

BEHAVIOR/TEMPERAMENT

Is child…	Quiet, calm, relaxed, patient?	Yes	No
	Active, outgoing, enthusiastic?	Yes	No
	Intense, demanding?	Yes	No
	Seem hyperactive, in perpetual motion all the time?	Yes	No
	Upset by transitions/unexpected changes?	Yes	No
	Passive, quiet, withdrawn?	Yes	No
	Rigid, set in his/her ways?	Yes	No
	Regular sleep patterns?	Yes	No
	Difficult to get to sleep?	Yes	No
	Destructive with toys?	Yes	No
	Short attention span?	Yes	No
	Very cautious/ afraid to try new things?	Yes	No
	Nearly impossible to take to the movies, church/temple or other settings that don't allow them to move around?	Yes	No
	Jump off tall furniture, climbs trees without regard to safety	Yes	No
	Have trouble keeping personal space neat/organized (desk, room)?	Yes	No
Comments:			

Because Rachel Benbow, here after referred to as the "therapist," must be aware of existing medical conditions, I have stated all known medical conditions and medications of the child for whom I am signing, here after referred to as the "client," and take it upon myself to keep the therapist informed about the client's updated physical health.

– I understand that the therapist cannot diagnose illness, disease, or any other medical, physical, psychological, or emotional disorder. I am responsible for consulting a qualified physician or medical practitioner for any physical/psychological ailments that I have.

– I understand that services offered by the therapist are not a substitute for medical care, and any information provided by the therapist is for educational purposes only and not diagnostically prescriptive in nature.

– I understand that Massage Therapy, CranioSacral Therapy and Reiki are therapeutic health aids.

– I understand that massage/bodywork is not appropriate care for infections or contagious illnesses or conditions. I will cancel my appointment as soon as I am aware of an infections or contagious illness or condition.

– I understand that the consumption of alcohol, recreational drugs, and pain killer pharmaceuticals can dangerously alter the client's ability to register and give feedback about pain or other vital sensations. Consumption of these items can also create detrimental and potentially deadly reactions when combined with massage/bodywork. I agree that the client will NOT consume alcohol, recreational drugs or pain killer pharmaceuticals prior to any treatment sessions.

– I understand that post treatment soreness can occur by the evening following a treatment session, and may last into the next day. In a small percentage of cases, soreness can last up to three days. Discomfort following treatment may be in an area that was treated, or in another area that is connected through a fascial restriction. The body's tissues can experience discomfort during the post-treatment period due to release of restrictions and reorganization of the tissue. Drinking plenty of water and getting rest may help to minimize the temporary discomfort experienced following a treatment session.

-- Similar to Occupational Therapy, the first few sessions, in addition to therapy work, focus on building rapport and trust between the pediatric client and the therapist. Trust is very valuable for facilitating therapeutic progress.

-- Changes in the client may be noticed after the first session, but, depending on the individual and their condition, it may take multiple sessions before changes are observed.

-- If the client does not use all their session, the rest of the session may be used to treat the care giver who is present. Please note, the session is for the child, and the child's therapy time is never to be undercut for anyone else to receive therapy work.

-- **All pediatric clients under the age of 18 must be accompanied by a parent or guardian at all times during a session.**

– I understand that if the client arrives late, the client's session will end at the originally scheduled time so the following client following is not penalized, and I will pay for the fully scheduled session.

– I agree to give 24-hour notice for a scheduled session that I cannot keep. I am aware that I may be charged the full fee for any missed sessions or for sessions that I do not give 24-hour notice to cancel or reschedule.

– I understand that the therapist is a volunteer responder for the CSMT Emergency Response Division, and that there may be rare occasions when the therapist may have to cancel and reschedule the client's session at short notice in order to assist at state or national emergencies/disasters.

– I understand that I will be charged, and agree to pay, a $2.75 processing fee when using a credit or debit card to pay for services or products. There are no additional fees for paying with cash or check.

– I understand that any illicit or sexually suggestive remarks or advances made by me or the client will result in immediate termination of the session, and I will be liable for the full payment of the scheduled appointment.

– I understand that I will not hold this establishment or therapist liable for anything related to this treatment.

– I agree that the client will actively participate as much as possible in their own healing.

_____

Print Client Name

_____

Print Parent/Guardian Name

_____ _____

Parent/Guardian Signature Date