Massages with Purpose and Skin Care

... Where Healing Begins

(321) 480-9986 MM35261 2070 Meadowlane Ave, W. Melbourne, FL 32904

PATIENT INFORMATION: **Today's Date:** _____

Child's Name: _____ Date of Birth: _____

Address: _____ City/State/Zip _____

Parent's Name: _____ Phone: _____ Email: _____

Has your child had a Professional Massage or CranioSacral Therapy before? Yes __ / No ___ If so, when _____

Referred By: _____

Please list your GOALS FOR THIS SESSION and areas of tension, stress and/or pain you wish to be addressed:

_____

_____

Please indicate any of the following that apply to you:

◯ Infectious Disease	◯ Headaches / Migraines	◯ Joint Pain	◯ Plagiocephaly (Raised on Side)	◯ Digestive Disorders
◯ HIV / AIDS	◯ High/ Low Blood Pressure	◯ Neurological Disorders	◯ Brachycephaly (Flat in back)	◯ Hemophilia
◯ Sprains/ Strains	◯ Heart condition	◯ Brain Injury	◯ Kidney Dysfunction	◯ PTSD
◯ Hydrocephalus	◯ Chiari Malformation	◯ Cancer	◯ Stroke	◯ TMJ / Grinding Teeth
◯ Epilepsy/ Seizure	◯ Anxiety __ / Depression__	◯ Chemotherapy/ Radiation	◯Buldging or Ruptured Discs	◯ Blood Clots

Please list any medical conditions, surgeries, injuries, broken/dislocated bones, or scars

(1) _____ (4) _____
(2) _____ (5) _____
(3) _____ (6) _____

Is there other information about you that your therapist needs to know prior to your session?

_____

_____

Your Child's Appointment Time has been reserved for them. Out of respect and consideration to your child's therapist(s) and other customers scheduled after them, please plan accordingly by putting your child's appointment time on your calendar and be on time**. 24 hour Cancellation Policy**, advance notice is required when cancelling an appointment. Massages with Purpose is unable to absorb the losses for no-shows or appointments cancelled less than a 24 hour period of the scheduled appointment. We understand how difficult it can be at times to deal with life's stressors and sudden illnesses, however, when a client does not show up for their session, it takes away an opportunity that could've been offered to someone else. For this reason, a full 24 hour notice is expected for cancellations & reschedules.
Late cancellations and no shows will be charged the full session fee. _____

I understand that my child is receiving therapeutic services that Massages with Purpose offers, at my own risk. In the event that my child become injured either directly or indirectly as a result, in whole or in part, of the aforesaid therapeutic services offered, I hereby hold harmless and indemnify the therapist, Massages with Purpose, their principals, and agents from all claims and liability whatsoever. I have read and understand that Massages with Purpose complies with the HIPPA privacy `requirements. _____

I have stated all conditions that I am aware of and this information is true and accurate to the best of my knowledge. I will inform my child's massage therapist if anything changes in my child's status. I understand that massage/bodywork I receive is for the purpose of stress reduction and the relief from muscular/structural tension, spasm or pain and to increase circulation, and is not a substitute for a medical examination or diagnosis and that I should take my child to their health care provider for those services. If I feel that my child is experiencing any pain or discomfort, I will immediately inform my child's massage therapist so that the pressure and/or methods can be adjusted to my child's comfort level. _____

CLIENT'S PARENT SIGNATURE _____ **DATE** _____