Consultation Form - Consent to Body Massage of Minor Child

Child Name:
Address:
Birth date:
Brothers and sisters:
GP Name:
Last visit to the doctor:

Parent/Guardian name:
Profession/occupation:
Address (if different to child):

The following information is required for health and safety, to benefit your child's health and provide a treatment that will best meet her/his individual needs.

While massage is a very safe treatment there are certain conditions that may require special attention, and it may be necessary for you to consult your GP before treatment can be given.

Information will be treated in the strictest of confidence.

CHILD DEVELOPMENT:

Ability to relax: good ☐ moderate ☐ poor ☐
Sleep pattern:
Nutrition: how many meal a day?
What are your children's favorite hobbies or toy?

Particular fears?
Digestive system:
Respiratory system:
Postural development:

MEDICAL: Has your child ever suffered from (tick as appropriate):

Any condition already being treated by a GP or another complementary practitioner
Cardio vascular conditions (thrombosis, phlebitis, hypertension, hypotension, heart conditions) ☐
Haemophilia ☐
Undiagnosed pain ☐
Medical oedema ☐
Nervous/Psychotic conditions ☐
Epilepsy ☐
Recent operations ☐
Diabetes ☐
Asthma ☐
Postural deformities ☐
Scar tissue (2 years for major operation and 6 months for a small scar) ☐

Any dysfunction of the nervous system (e.g. Multiple sclerosis, Parkinson's disease, Motor neurone disease) ☐
Bell's palsy ☐
Trapped/Pinched nerve (e.g. sciatica) ☐
Inflamed nerve ☐
Cervical spondylitis ☐
Spastic conditions ☐
Kidney infections ☐
Slipped disc ☐
Taking prescribed medication ☐
Allergies ☐

General health: Today does your child have:

Fever ☐
Undiagnosed lumps and bumps ☐
Localised swelling ☐
Inflammation ☐

Cancer ☐
Abrasions, Bruises, Cuts ☐
Skin diseases/ fever/contagious disease ☐
Is GP referral required? Yes ☐ no ☐

Parents/guardian declaration:

I declare that the information I have given are correct, that I have not withheld any information concerning the receiver's health and that I will advise of any changes if and when they occur. I have been informed about contraindications and I am willing to proceed with treatment. I acknowledge that there is a possibility of developing some minor, temporary reactions following treatment.
I understand that massage is not a substitute for medical treatment.

Signature of parent/guardian(s) **Date:**