CONFIDENTIAL HEALTH HISTORY FORM

Welcome to The Little Massage Company! An accurate health history is important to ensure that we deliver a safe and effective treatment. If your current health status changes in the future please let us know so we can update your file. Please note that all information on this form is confidential.

Child/Patient's Name: _____

Date Of Birth: (M/D/Y) _____ **Gender:** _____

Address: _____ **City:** _____ **Postal Code:** _____

Email: _____

Name Of Parent/Guardian: _____ **Phone Number:** _____

PLEASE READ AND ANSWER ALL QUESTIONS BELOW

Any complications at ***birth, disabilities, allergies or medical conditions, surgeries or other relevant health concerns*** we should be aware of?

Was your child born premature - *If yes how early?*

Have you noticed any of these symptoms in your child? Please circle any that apply.

- Reflux/Spit Up
- Colic/Gas
- Sleep Problems
- Breast Fed or Bottle Fed

Is your child presently taking any prescribed medication(s)? If yes, please list the medication(s) and the condition(s) for which it is being used.

Please read all the following information carefully and sign accordingly

I acknowledge and understand that my child is unable to receive a massage if they have any of the following:

- High Fever
- An acute infection/illness/disease
- Contagious skin disorder
- Open sores or lesions
- ***Had recent immunizations (wait 48-72 hours)***
- Swollen lymph nodes
- Blood clots or other blood conditions
- Diarrhea or other sickness (must be 72 hours symptom free

INITIAL _____

I understand that it is mandatory for parents/guardians to be present during the treatment of minors. You will also be required, if needed to assist the minor in preparing for your child's treatment.

INITIAL _____

I acknowledge and understand that it is my responsibility to inform the Massage Therapist of any health changes to the information provided on this form. I consent that all the information provided is accurate and current.

INITIAL _____

I consent/give consent to therapeutic massage treatments.

INITIAL _____

I understand that all information provided on this from is confidential.

INITIAL _____

Cancellation/No Show Policy: I understand that a minimum of 24 hours notice is required for cancelling or rescheduling of appointments at The Little Massage Company. Failure to do so will result in a $25.00 fee. Payment will be the responsibility of the client directly and not of the insurance company.

INITIAL _____

I understand that if I become unwell or experiencing any flu/cold like symptoms, I will cancel and reschedule for a later time (minimum of 10 days) Please understand that we want to ensure the safety and health of all our lovely clients as well as our staff, so we appreciate your honesty with how you are feeling

INITIAL _____

Signature _____

Date: _____