CONFIDENTIAL CLIENT HISTORY FORM

An accurate health history is important to ensure that it is safe for you to receive a massage treatment. If your health status changes, please let us know. All information gathered is confidential except as required or allowed by law.

PERSONAL DATA

Child's Name:_____ **Birth Date (MM/DD/YYYY):**_____/_____/_____ **Today's Date:**____/____/____

Referred By:_____ **Family Physician/Pediatrician:**_____

Parent/Guardian's Names:_____ **Email:**_____

Home Phone#:_____ **Work#:**_____ **Cell#:**_____

Address:_____ **City:**_____ **Prov:**____ **Postal Code:**_____

How did you hear about us?:_____ **Hobbies:**_____

Emergency Contact:_____ **Tel#:**_____

Payment Method: Cash | Etransfer | Cheque | Credit Card - Frequency of Payment - 1st lesson or halfway through

HEALTH HISTORY

1. **What is your child's diagnosis (if any)?**
   _____
2. **What is your primary reason for seeking therapy?**
   Please specify: _____
3. **Are you presently receiving other treatments (Physio, OT, Speech, Chiro, Massage, etc.)? Yes____ No ____**
   If yes, please specify: _____
   Name(s) of practitioner: _____
4. **Do they have tubes or devices attached? Yes____ No____**
   If yes, Please specify: port, shunt, feeding tube, or other: _____
   If so, since what age? _____
   _____
5. **Do they use support devices such as AFO's, braces, splints, standers, special chairs, wheelchair, walker, etc.**
   If so what kind and how often are they worn or used? _____
   _____
6. **Do they use a jumping device, baby swing, or rolling/scooting device?** _____
   If so what kind and how often are they worn or used? _____
   _____
7. **Please describe any surgical procedure, accident, or muscular/skeletal problem or pain that has required medical care:**
   _____
   _____
8. **Are they taking any medications? Yes___ No ___ If yes, please specify reason for taking (ie: cholesterol, anxiety, etc.):**
   _____
   _____
9. **Are they able to feed well? Do they nurse or feed by mouth? Please comment here:** _____

_____

10. Does your child sleep well? Yes____ No____ If no, briefly explain:_____

_____

11. Does your child have floor time each day? Yes____ No____ How much time each day? _____

12. Approximate Date of last:

Complete physical exam: _____ EEG: _____ X-ray: _____ MRI: _____ EMG: _____

CT Scan: _____ Other: _____

13. What are they currently able to do <u>on their own</u>? (check all that apply):

Roll L / R	_____	**Pull up to stand**	_____	**Say words**	_____
Roll to tummy	_____	**Walk or toddle**		**Say sentences**	_____
Reach for toys	_____	**along furniture**	_____	**Make eye contact**	_____
Play with toys	_____	**Walk**	_____	**Self-feed**	_____
Come up to sit	_____	**Jump**	_____		
Army crawl	_____	**Laugh**	_____		
Crawl	_____	**Babble**	_____		

Other Skills: _____

14. Please list a few favorite songs/activites/games, etc. here: _____

_____

15. Is there anything else you would like to add to help me better understand and help your child?

_____

_____

<u>INFORMED CONSENT TO ABM NeuroMovement TREATMENT</u>

I understand that the ABM Practitioner is providing ABM NeuroMovement Lessons within their scope of practice.

I hereby consent for my Practitioner to treat me with ABM for the above noted purposes including such assessments, examinations and techniques.

I acknowledge that the Practitioner is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that ABM is not a substitute for a medical examination. It is recommended that I attend my personal physician for any ailments that I may be experiencing. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I acknowledge that with any treatment there can be risks and those risks have been explained to me and I assume those risks.

I acknowledge and understand that the Practitioner must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my Practitioner and disclosed to the Practitioner all of those medical conditions affecting me. It is my responsibility to keep the Practitioner updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

I authorize my Practitioner to release or obtain information pertaining to my condition(s) and/or treatment to/from my other caregivers or third party payers.

I have read the above noted consent and I have had the opportunity to question the contents and my lesson. By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me and such additional treatment as proposed by my Practitioner from time to time, to deal with my physical condition and for which I have sought treatment. I understand that at any time I may withdraw my consent and treatment will be stopped.

MOVE Therapies reserves the right to charge the full applicable treatment fee for missed or cancelled appointments if 24 hours notice has not been received*. Subject to change without notice.*

***** Client Signature: _____ Date:**_____

Client's Parent/Legal Guardian (if under 18 years old): _____

Parents and/or legal guardians of clients under 16 years of age are required to be present in the treatment room during all treatments and or consultations. NO EXCEPTIONS! Clients between 16 and 18 years of age require written consent prior to commencing treatment and or consultations.