



**Body in Mind Therapies**  
**Massage and Movement Centre**

2911C Cleveland Ave.  
 Saskatoon, SK S7K 8A9  
 (306) 715-2354

**CONFIDENTIAL CLIENT HISTORY FORM - CHILD**

An accurate health history is important to ensure that it is safe for you to receive massage therapy or Anat Baniel Method services. 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: \_\_\_\_\_

Would you like to be added to BIMT's email newsletter for special promotions and health tips? (Please Circle) YES // NO

**HEALTH HISTORY**

1. What is your child's diagnosis?: \_\_\_\_\_

2. What is your primary reason for seeking help?  
 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: seizures, 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 on their own? (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/activities/games, etc. here: \_\_\_\_\_

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

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**INFORMED CONSENT TO MASSAGE THERAPY TREATMENT AND ANAT BANIEL METHOD LESSONS**

I understand that the massage therapist or Anat Baniel Method Practitioner is providing services within their scope of practice as defined by their governing body (ie: Massage Therapist Association of Saskatchewan, Inc.).

I hereby consent for my therapist/practitioner to treat me for the above noted purposes including such assessments, examinations and techniques, which may be recommended, by my therapist/practitioner.

I acknowledge that the therapist/practitioner is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that massage therapy and the Anat Baniel Method are not substitutes 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 therapist/practitioner must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my therapist/practitioner and disclosed to the therapist/practitioner all of those medical conditions affecting me. It is my responsibility to keep the massage therapist/practitioner updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

I authorize my therapist/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 therapy. 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 therapist/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.

**Body in Mind Therapies – Massage and Movement Centre 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.**