The Way of Touch

Kids & Teens Health History

Information obtained will help to address the session according to your current needs. Your personal information is kept strictly confidential.

Child Name ____________________________________

Parent Name ___________________________________

Date _______________________________ Birth Date ______________________________

Home Phone _________________________ Mobile Phone ___________________________

E-Mail ______________________________

Birth Complication ? ____

Current Health Issues ? ____

Recent Surgeries ? ____

Hospitalization ? ____

Special Needs ? ____

Medication ? _______________________________ Allergies ? ______________________________

Any skin rashes or other problems now? ____

Have your child had any previous experience with massage / bodywork ? Yes _____ No ______

If yes, please explain ____

____

What are your expectations from these Sessions? _____________________________________

____

Do you have any questions about Massage in general or about this session? ____________________

____

Does your child sleep well? ____

____

Any exercise ? ____

ALL THE INFORMATION DISCUSSED DURING TREATMENT WILL REMAIN CONFIDENTIAL.

<u>Consent or Treatment of Minor or Dependent</u>

By my signature and date below, I hereby authorize ___________________________

to administer massage, bodywork, or somatic therapy techniques to my child or dependent, as she deems necessary and appropriate in her capacity as a licensed massage therapist.

__________________________________ __________________________________

Signature Date

Thank you,

Yifat Donenfeld - BCTMB, LMT
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