CLIENT INTAKE FORM

Child's Name _____ **DOB** _____ ❑ **Male** ❑ **Female**

Address _____ **Weight :** **Height :**

Parent/Guardian Name(s) _____

Phone _____ **E-mail:** _____

Emergency contact _____ **Phone** _____

Medical & Developmental History

1. **Birth type: □ Vaginal □ C-section □ Assisted (forceps/vacuum). Please specify:**

   _____

2. **Any pregnancy or delivery complications?** _____
3. **Surgeries, injuries, or hospital stays (with dates if known):**

   _____

   _____

4. **Diagnosed conditions (e.g., torticollis, tongue tie, reflux, scoliosis):**

   _____

5. **Known allergies or sensitivities?**

   _____

Fascial Observation & Concerns

1. **What brings you in today**

   _____

   _____

2. **Does your child favor a head tilt, limb, or avoid certain movements?**

   _____

3. **Any digestive, sleep, or fussiness concerns?**

   _____

4. **Have you noticed tension, fear, or strong reactions to touch?**

   _____

Your Child's Rhythm & Comfort

1. **Any favorite comfort items or routines we should know about?**

   _____

   _____

   _

2. **What brings your child a sense of safety or calm?**

   _____

   _____

*** BFM therapists do not diagnose conditions nor do they prescribe medical treatment, prescribe substances, nor interfere with the treatment of a licensed medical professional. As a holistic healing BFM does not take the place of medical care.**

*** It is recomended to see a licensed physician or licensed health care professional or psychological ailment you may have.**

I understand this session is therapeutic and not medical treatment. I consent to gentle fascia work for my child.

Parent/Guardian Signature: _____ Date: _____