*Intake Form*
*Parent-baby Massage Program*

Training Date: ______________________________
Parent's Name:_______________________________ Baby's Name: _______________________
Baby DOB:_______________________________ Contact Number:_____________________

Regarding your baby:

1. Is your baby/child under the care of a physician?

2. Any history of hospitalization?

3. Is your baby/child currently taking medicine?

4. Does your baby/child have heart issues?

5. Circulatory conditions? Skin problems? Allergies

6. Developmental Hip Dysplasia?

7. Hernias?

8. Feeding Issues? Sleeping problem?

9. Jaundice?

10. Crankiness, fussy, colic?

11. Emotion or preterm underweight?

12. Does your baby/child have any special situations of concern regarding massage?

Others:_____________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________