the magical ones
Bek Wiltbank, MOTR/L

425-814-2045
425-814-2783 fax

Health History

Patient Name:________________ Date of Birth:____________________

Who may I thank for referring you? ____

Reason for bringing your child in for therapy? (Please include any physical, mental, emotional symptoms your child is having, and any diagnoses your child has been given:)

What are YOUR goals for treatment?

School situation: Please describe your child's experience at school. Able to focus? Fidgety? Has friends?, etc.

Any accidents, injuries, or surgeries? No ____ Yes ____
If yes:

Birth and Infancy History:
____ Caesarian delivery ____ Forceps or vacuum suction delivery?
____ Labor difficulties______________________
____ Anesthesia/epidural__________________________
____ Breast fed or ____ Bottle fed ____ Vaccinations _____________________________
____ Severe colic or sucking problems_________________
____ Pacifier use How long? ___________________
____ Ear inflammations/infections
____ Frequent illnesses ________________________

Health History:
____ recent dental work
____ orthodontia/braces
____ TMJ problems
____ Grinds Teeth
____ headaches
____ specific medical condition?________________________________
____ mouth breathing ___day ___ night
____ snores
____ allergies ____
____ sleeps through the night
____ wets bed
____ asthma or respiratory problems
____ childhood illnesses______________________________

Is your child receiving other medical care or therapies? yes______ no_______
If so, please list type and contact information of provider:

Pediatrician/Primary Care Provider:

Name:_______________________________________ Phone: __________________________

Has your child ever had Craniosacral Therapy? __________

Personal habits: Television? Hours/week ________ Computer/Video Games? Hours/week ________

Movies/videos? Hours/week _____ Bedtime at ___pm Wakes up at ___am Hours of sleep _______

Does your child exercise regularly, what activities? ____

Nutritional habits: # vegetables per day ______ # fruits per day ______ whole grains ______

Meat & chicken? ______ fish? ________ Water: :oz. per day?_____ supplements?_______________

As the parent/guardian of a minor child, your signature below signifies your authorization for his/her treatment:

Signature:_____________________________________ Date:_________________________

Relationship to child:___________________________

I Authorize the release of information to my child's Primary Care Provider listed above

Additional providers to send assessment and/or notes to:

Name:______________________________ Title: _____________________
Phone and/or fax: ________________________

Name:______________________________ Title: _____________________
Phone and/or fax: ________________________

Signature:_____________________________________ Date:_________________________

I authorize The Magical Ones to send email and/or text reminders for appointment times. I acknowledge that this information is sent over electronic means that are not confidential.

Signature:_____________________________________ Date: _______________________________