Infant Massage Instruction

Consultation Form

Infants Name:	D.O.B
Parent/Carer Name:	Contact Tel Number: Email: Emergency Contact:
6/8 week medical check date:	GP:

Any medical concerns (including colic, reflux, constipation):
Current Medications:
What would you most like to achieve from the infant massage instruction:

Do you /or your baby have any mobility needs that may require assistance on the day (therapy rooms are above the Neal's Yard shop)

Please consider the following contraindications (when not to massage):

Fever/temperature
Within 48 hrs of immunisation
Severe allergies
Open wound/skin disorders
Vomiting
Severe diarrhoea
Recent surgery

This list is not exhaustive so please check with me if you are concerned about any health issues/conditions your baby has or if you have any concerns whether massage is suitable for your baby at this time.

Disclaimer:

I have read and understand the above contraindications and will take full responsibility for myself and my baby during the massage sessions.

I will inform the Baby Massage Instructor of any health issues, if in doubt I will seek professional medical advice prior to booking.

SIGNATURE:	DATE:

Please email this completed form to helenmanister@gmail.com preferably before your appointment if possible.

FHT professional standards authority accredited register
I'm a registered therapist, so you know I'm qualified and insured