Master Moves Studio
Child Intake Form & Release of Liability

Please fill out the form below as thoroughly as possible. If some questions do not pertain to you, simply write: "N/A" or "NO" in the proceeding text boxes.

* Required

BASIC INFORMATION

Parent Name *

____

Parent Name *

____

Contact Phone *

____

Contact Email *

____

Mailing Address *

____

Child's Name *

____

Child's Date of Birth * ______________________

Please List Names and Ages of All Other People Living in the Home:

Name	Age	Relationship	Primary Language	Secondary language

Reason for visit:

____

____

Source of referral:

☐Word of Mouth ☐Internet ☐Support Group

☐Physician ☐ABM Directory ☐ Other_________________

BIRTH HISTORY

Pregnancy: ☐Normal ☐Complications (please explain briefly)

____

____

Labor: ☐Spontaneous ☐Induced ☐Premature ☐Complicated (please explain briefly)

____An
esthesia: ☐None ☐Epidural ☐Spinal ☐Other (please explain briefly)

____De
livery: ☐Cesarean ☐Vaginal ☐Breech ☐VBAC ☐Forceps ☐Vacuum

Single Birth: ☐Yes Multiple Birth: ☐Twins ☐Triplets ☐Other

____

Gestational Age: ____ weeks Birth Weight: ____ Kg ____ grams

Apgar Score: _________ at 1 min. _________ at 5 min. _________ at 10 min.

NICU: ☐No ☐Yes _____ days _____ weeks ____ months

Other complications:

____

____

RELEVANT MEDICAL HISTORY

Illnesses, Injuries, Surgeries, & Hospitalizations since birth: (Check all that apply)

- ❏ Meningitis ☐Hernia repair ☐VP shunt ☐Head injury ☐PDA repair ☐Tracheostomy ☐Bone fracture ☐Circumcision ☐Frequent ear infections ☐Encephalitis ☐G-tube insertion ☐Failure to thrive

Other: ____

Digestion: ☐Frequency of bowel movements: ☐More than once daily ☐Once daily ☐Once in 2 days ☐Identified problem of chronic constipation ☐Frequent diarrhea

Medications:

____

Supplements:

____

Allergies:

____

Immunizations: ☐Regular Schedule ☐Altered Schedule ☐Other (Explain)

____

Medical Diagnoses with which your child has been labeled: ☐ Cerebral Palsy ☐Seizure Disorder ☐Hypotonia ☐Autism Spectrum Disorder ☐Developmental Delay ☐Chromosomal Abnormality ☐Other (Describe)

____

Pediatrician / Family Physician:

Name: ____

Address:

____

Telephone: ____________________________ Fax: ____________________________

Neurological Evaluation:

Date & Results (including MRI's):

____

____

Neurologist Name:

____

Address:

____

Telephone: ____________________________________

Orthopedic Evaluation:

Date & Results:

____

____

Orthopedist Name:

____

Address:

____

Telephone: ____

Vision Test: Date & Results:

____

____

Ophthalmologist Name:

____

Address:

____

Telephone: ______________________________________

Hearing Test:
Date & Results:

____

____

Previous Therapy Interventions:

School-Based: ☐PT ☐OT ☐ST ☐Other (explain):

____

____

____ Private

Therapy: ☐PT ☐OT ☐ST ☐Other (explain):

____

____

Other Physicians and Surgeons involved in child's care with address & telephone:

____

____

____

____

Complementary or Alternative Health-care Professionals Consulted (Check all that apply and provide name, address, and telephone of each)
Osteopath _________________
Craniosacral Therapy _____________________________ _____________________________
Nutritionist ________________ _____________________________
Homeopathy ______________ _____________________________

Massage _________________ ____________________________
Other
____
____
____

DEVELOPMENTAL HISTORY (Please note approximate ***age in months*** for each)

Rolled Over: _____ stomach to back _____ back to stomach _____ for locomotion

Sitting: _____ stayed sitting when placed _____ got self into sitting position

Crawling: _____ on belly _____ rocking on hands & knees _____ creeping on hands & knees

Standing: _____ held weight _____ stayed up when placed _____ pulled self up to stand

Walking: _____ stepping with hands held _____ cruising around furniture _____ steps without support _____ walking independently more than 10 steps

Walking on toes: Never Rarely Occasionally Frequently

Jumping: _____ in place _____ over a line _____ off of step (_____ height) _____ over obstacles

Hopping 3 or more times: _____ on right foot _____ on left foot

Falls: Never Rarely Occasionally Frequently

Baby Devices Used: (age in months & estimated hours per day)
Sling ________ Swing ________ Exersaucer ________ High Chair ________ Johnny Jump-up ________ Pac'n Play ________ Bumpo or other sitter ________ Other (describe)
____

Manipulation (age in months): Hands to mouth ________ holding objects ________ holding object in both hands simultaneously _______ banging two objects together ________ manipulating toys like pop beads or shape sorters ________ scribbling ________ participating in dressing ________ dressing oneself ________ holding bottle ________ feeding oneself using fingers ________ feeding oneself using utensils ________

Toileting (age in months): urinating or defecating in toilet when placed there ________ initiating use of toilet ________ reliably uses toilet ________ stopped wearing diapers _________

Communication (age in months): looks at caregiver ________ smiles ________ cooing &/or babbling ________ gestures bye-bye ________ uses 5 words ________ speaks in sentences ________

Feeding: Breast-feeding ________ bottle feeding ________ puree ________ coarsely ground food ________ Cut-up table food ________ Favorite Toys: ____

Favorite Activities &/or Positions: ____

Response to Music or Singing: ______________________________

What is your child currently able to do on his / her own? *

(check all that apply)

- ❏ Track object with eyes
- ❏ Turn head to both sides
- ❏ Roll to each side
- ❏ Reach for toys
- ❏ Transfer objects
- ❏ Roll from back to belly
- ❏ Roll from belly to back
- ❏ Push up on belly
- ❏ Babble or make sounds
- ❏ Prop sit
- ❏ Come to sit
- ❏ Army crawl
- ❏ Crawl on hands and knees
- ❏ Stand on knees
- ❏ Come to standing
- ❏ Cruise along couch or furniture
- ❏ Stand independently
- ❏ Self-feed
- ❏ Walk
- ❏ Talk
- ❏ Other

If selected "other" please describe: *

____

Is your child using support devices in therapy, home, or school settings? *

- ❏ Yes
- ❏ No

If so, please describe which ones and how often they are used? (baby swings, jumping devices, special chairs, walkers, standers, AFO's, braces, splints, wheelchair, etc.) *

____

How much floor time does your child have each day? *

____

What sort of activities does your child like and dislike? *

____

How would you describe your child's nature? (quiet, inquisitive, restless, anxious, playful, etc.) *

____

Please describe mealtimes with your child. (nursing, bottle fed, tube-fed, self-feed, other) *

____
____
____

What is your child's sleeping schedule? (still napping, what time of day, how long) *

____

Please describe briefly your child's daily routine. *

____

Is there anything else you would like to add to help me better understand your child? *

____

What short term goals would you, as a parent, like to see your child accomplish in the upcoming months? *

____
____
____

CONSENT AND WAIVER

_____________ I hereby give consent to Master Moves Studio to provide lessons for my child.

______________ I understand that this work is intended as an instruction in the optimal use of the self but that no guarantees have been made concerning the outcome of the lessons. I realize that this program is not a treatment for medical emergencies and is not intended as a substitute for medical procedures suggested by my child's medical professionals. I fully understand that nothing told to me by a practitioner in the lesson is a medical diagnosis, nor do I consider it so. I agree to assume all risks and responsibilities of this participation.

Sharadamba Kota and/or Master Moves Studio make no warranties or guarantees concerning any particular outcome, result, or improvement from participation in functional synthesis and/or movement lessons. Sharadamba Kota and/or Master Moves Studio are not responsible for any direct, indirect, consequential, special, or other damages, including, but not limited to economic loss, injury, or illness, that may result from participation in functional synthesis and/or movement lessons.

Sharadamba Kota/ Master moves Studio has the right to determine when it is unsafe to proceed with or discontinue any lesson due to health-related concerns or any other concerns.

______________ In exchange for the ability to participate in these lessons, I hereby remise, release, and forever discharge Master Moves Studio, as well as their agents, from all manner of actions, suits, proceedings, judgments, damages, claims, and demands in law or equity, which Releasor has or may have as a result of lessons or other services, supplies or instructions provided by or on behalf of Master Moves Studio.

____________ I understand that this agreement and release of liability applies to this and any and all future lessons or dealings that I may have with Sharadamba Kota/ Master Moves Studio.

___________________I understand that I am responsible for giving at least 48 hours notice for any cancellation; otherwise, I am still responsible for payment for the missed lesson.

Client's Signature: ____
Client's Name (Printed) ____
Date:__________________

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