

INFANT MASSAGE INTAKE FORM

Family Resource Counseling Center

11500 West Olympic Blvd. Ste. 420

Los Angeles, CA 90064

Phone: 310-479-9798 / Fax: 310-479-9796

Parent/Legal Guardian Name/s: _____

Address: _____

Phone #: _____ **E-mail:** _____

Infant's Name: _____

Date of Birth: _____ **Age:** _____

Pediatrician's Name: _____ **Phone #:** _____

Are you interested in the group class or private training? _____

Who will be attending the training? _____

Are there any special health or development considerations with your infant?

How did you hear about the class? _____

Please sign to indicate the above information is correct and that you agree to pay for and attend the six-week class:

Name: _____ **Date:** _____

Please **fax** this intake form to **(310) 479-9796** or mail to:
11500 West Olympic Blvd. Suite 420
Los Angeles, CA 90064

If you have any questions, please contact **Sara Abbot, Psy.D., CIMI** at (310) 479-9798 ext. 3, otherwise, you will be contacted via phone with the class information.

We look forward to working with you and your child!