Infant Craniosacral In-take Form

Child's Name: ____ D. o. B.________________

Main reason for visit: Well baby check ________ Concern (note here)_____________________________________

____

Address ____

Best Telephone_____________________________________ E-mail ____

Mother's/Father's Name:____

Siblings (name/age)____

Referred by: ____

HEALTH CARE PROVIDERS

Pediatrician ____ Lactation Consultant ________________________________

Chiropractor ______________________________________ Naturopath ____

Homeopath _______________________________________ Occupational Therapist ___________________________________

Physical Therapist _________________________________ Other ____

BIRTH

Length of Pregnancy: __________________

Length of Labor; how labor started and progressed:
____
____
____

Baby's birth weight: ____________ APGAR Score at 1 minute: ________________ At 5 minutes: ______________________

IF APGAR low, note problem: color breathing heart rate muscle tone vocal

LABOR AND DELIVERY

Who attended your birth ____

Planned location of birth: ____________________ Actual location of birth: ________________________

Please circle any events that occurred during your child's birth:

o Induction – type ____________ o Other anesthesia o Prolonged labor

o Epidural o Very fast labor o Placenta previa

NEWBORN

Please check any items that applied to your child birth and as a newborn:

o Breech or difficult presentation

o Cord around neck

o Baby stuck during labor

o Fetal distress ________

o Fetal monitor (type) _________________

o Forceps

o Umbilical cord clamp early

o Caesarean- Planned Emergency

o Difficulty delivering placenta

o Vacuum extraction

o Required incubation

o Separation from you; how long? _______

o Delayed first breath

o Required resuscitation

o Other difficulty breathing

o Choking

o Swallowed meconium

o Surgery

o Vitamin K

o Erythromycin

o Blue at birth

o Red (not pink) at birth

o Heavy bruising (where)

o Forceps marks (where)

o Crying excessively

o Uneven eye size or placement

o Uneven ears

o Mis-shapen head after fifth day

o Sleeping excessively

o Lethargic/limp

o Jaundice (how long) ________________

o Difficulty latching

o Difficulty breastfeeding

o Formula supplementation

o Formula feeding

o Genetic conditions

Other major events, or medications & interventions used, if any

Infant Health

Please circle or check any events that apply during infancy:

o Persistent breastfeeding problems

o Nipple pain

o Plugged ducts or engorgement

o Mastitis

o Poor weight gain

o Colic

o Inconsolable crying

o Sensitivities or allergic reactions to:

Breast milk ___________________

Formula _____________________

o Gassy

o Persistent spitting up

o Projectile vomiting

o Thrush

o Persistent cradle cap

o Persistent rashes

o Colic

o Very smelly stools

o Constipation or difficult bowel movements

o Poor eye contact

o Does not like to be held

o Arches back frequently

o Rigid back,legs or arms

o Turns or tilts head to one side only

o Startles frequently or persistently

o Dislikes (or disliked) being placed on tummy

o Delay or skipped rolling

o Delay in coming to sit on his/her own

HEALTH and NUTRITION

Please indicate if your child has received any of the following:

o Breast milk

o Commercial formula

o Cow's milk

o Goat's milk

o Soymilk

o Solid foods: ________________________
____

RELEASE

Release of Liability and Client Responsibility

Please take a moment to carefully read the following information and sign where indicated. Your signature indicates that you have agreed to these terms.

If your child has a specific medical condition or specific symptoms, massage/craniosacral therapy may be contradicted. Because massage/craniosacral therapy and developmental movement therapy/reflex integration should not be performed under certain medical conditions, I affirm that I have stated all my child's known medical conditions and answered all the questions honestly. I agree to keep the practitioner updated as to any changes in my child's medical profile and understand that there shall be no liability on the practitioner's part should I forget to do so. A referral from your primary care provider may be required prior to service being provided.

I understand that the myofascial massage and craniosacral therapy that my child receives is provided for the basic purpose of relaxation of connective tissue tension and restoration of the craniosacral rhythm. I understand that developmental movement therapy/reflex integration is provided for the activation of key neural connections. If I notice that my child is experiencing any pain or discomfort during a session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my child's level of comfort.

I further understand that myofascial massage/craniosacral therapy and developmental movement therapy/reflex integration should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailments of which I am aware of in my child. I understand that massage/craniosacral therapy practitioners and developmental movement therapy/reflex integration practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such.

Payment Policy

Payment is due on the day of service. I can generate a statement for your insurance carrier or flex plan to facilitate your reimbursement request. Please check your benefit coverage first. Your service may be eligible for flex plan coverage if your employer offers this benefit.

Client statement: I understand that payment is due on the day of service. Further, I agree to pay a processing fee of $25 for each payment that are not made on the day of service and additional bank fees for any check or debit that does not clear. I understand that the practitioner may discontinue sessions if payments are not current.

Cancellation Policy

Client statement: I agree to comply with the cancellation policy, which requires 24 hours notice to Heather Becton Hunt for any rescheduled or cancelled appointment. If I do not provide 24 hours notice, I will be responsible to pay the posted fee.

Parent/Guardian Signature ___________________________________ Date ________________