**Newborn~Infant CST/CFT Intake**

Client Name: DOB:

Parent/Guardian Name:

Address:

City/State/Zip:

Email:

Cell: Referred by:

**Gestation History**

* Length of pregnancy (# of weeks) \_\_\_\_\_\_
* Did any of the following occur during pregnancy? Accidents New diagnosis medications

If yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Labor/Delivery History**

* How long was labor?
* How much time was spent pushing?
* Were you induced?
* Methods of pain control used?
* What was baby’s presentation at birth? NormalBreech
* What type of delivery did your child have? VaginalC-Section
* Where was your baby born? Home Hospital Birthing Center
* Were forceps or suction used to assist in your child’s delivery? No
* Did your child breathe on his/her own after being delivered? Yes or No
* Were there any concerns with the umbilical cord during birth? Yes or No
* If yes, choose: loosely wrapped tightly wrapped knotted
* Where was it wrapped?

**Post-Natal History**

* Was your baby in intensive care? Yes/No
* Was your baby blue after delivery? Yes/No
* Does your baby struggle latching to breast or bottle? Yes/No
* Does your baby spit up frequently? Yes/No
* Does your baby have heartburn? Yes/No
* Does your baby have colic? Yes/No
* Does your baby have constipation? Yes/No
* Does your baby have strabismus (lazy eye)? Yes/No
* How is his/her sleep schedule?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Has he/she had a typical or adjusted vaccination schedule?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Which of the following describes your child’s diet?

Breastfed Bottle fed No restrictions Dairy-free Vegetarian Other

Priority concerns: List medications: List and date surgeries:

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**Please list supporting providers (first and last name):**

Lactation Consultant:

Chiropractor:

Pediatrician:

Dentist - TT release:

Other:

**Please initial each of the following and sign at the bottom**

* \_\_\_\_\_\_ I do not diagnose or treat conditions, prescribe medication, or manipulate joints.
* \_\_\_\_\_\_ I authorize the bodywork practitioner to speak with other healthcare providers that are involved in caring for my child (such as; my lactation consultant, chiropractor, speech/language therapist, dentist, etc).
* \_\_\_\_\_\_ Payment for each session is due at the time of visit.
* \_\_\_\_\_\_ I understand that I may be financially responsible for a missed or rescheduled appointment if not cancelled/changed by phone/text 24 hours prior to the reserved session time.

Signature/date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_