The Roots of Health

CranioSacral Therapy, Therapeutic Massage, Reiki
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Infant Client Intake Form (birth to 1 yr old)

Client Information

Infant Name: _____ Today's Date: _____

Date of Birth: _____ Current Age: _____

Primary Caregiver's Name: _____ Relationship: _____

Phone: _____ Occupation: _____

Email: _____

Home Address: _____ City: _____ State: ____Zip: _____

Referred By: _____

Primary Physician Name and Phone: _____ (____) _____

Emergency Contact Name and Phone: _____ (____) _____

Unless specifically noted otherwise, provision of contact information assumes permission for The Roots of Health to contact you with questions or information related to your therapy, general information, or promotional offers.

General Information

Describe your primary concern(s) regarding your child. _____

_____

_____

_____

At what age did you first become concerned? _____

On a scale of 1 to 10 (1 being the least), what is the amount of stress in the primary caretaker's life? _____

On a scale of 1 to 10, what is the amount of stress/tension in the home? _____

Anything else about home or family life that would be helpful for you to share? _____

Medical Information

Currently under care of health practitioner for a specific condition/illness? ___ Practitioner's name: _____

Condition/Illness: _____

List current medications and purposes: _____

_____

List major injuries/accidents/illness. Please circle any still affecting infant: _____

_____

Surgeries & hospitalizations: _____

_____

List any allergies (food and nonfood): _____

Did / does your child suffer from frequent ear infections? If yes, list number since birth.:

_____

MATERNAL / PRENATAL HISTORY

Number of pregnancies _____ , number of children _____, ages of children _____
Maternal age at client's birth _____
Maternal health during pregnancy and/or any complications of the pregnancy
_____

Was the baby stuck in an unusual position for an extended period during gestation (for example, head jammed under mother's ribs)? If so, please describe.
_____

CHILD'S BIRTH

Length of gestation (please circle one):
Full term
Premature (# of weeks early ____)
Postmature/prolonged pregnancy (# of weeks late ____)

Type of delivery (circle all that apply):
Vaginal; breech (feet first); sunny side up (occiput posterior position); C-section

Note complications of delivery, including medications and/or epidural.
_____

Was manual birth assistance required (Y/N)? If yes, please circle one, and list # of tries.
Forceps _____ , Vacuum Extraction _____

Was suctioning at birth required (Y/N)? If yes, please circle which ones.
Mouth, nose, lungs, stomach

Cord around neck (Y/N)?

Congenital abnormalities? If yes, please describe.
_____

Medical complications as a newborn (jaundice, seizures, infections, etc.)?
_____

Require hospital stay at NICU? If so, how long and please describe stay.
_____

Surgery as a newborn? If yes, please describe.
_____

Receive vaccines, if so which ones?
_____

Vaccine complications or injury? Please describe.
_____

Circumcision if male? (Y/N) If there were complications, please describe.

<u>CURRENT BEHAVIORS/CONDITIONS</u> (Please circle ALL that apply)

Behavior:
Hypertonic (tense, arms contracted into body, scissoring of legs)
Hypotonic (floppy, low muscle tone for age)
Frequent crier/colicky
Generally happy/content

Feeding:
Breast fed, bottle fed, combination
Gulps air, gets tired feeding, uncomfortable feeding in certain positions, clicking while feeding, difficulty with flanging lips, difficulty with coordinating tongue
Pain for mother during breast feeding
Reflux
Tongue tie revision, lip tie revision, both

Gastrointestinal:
Constipation/infrequent bowel movements (if yes, list how often)
Diarrhea
Pain with bowel movements or passing gas
Displays discomfort during tummy time or when belly is touched

Sleep:
Please describe sleep habits

_____

Developmental delays:
Please list any developmental delays, and include the approximate length of the delay

_____

Please list any regressions in development:

_____

Surgeries, major illnesses or major injuries not already listed:

_____

ADDITIONAL COMMENTS FROM INFANT'S CARETAKER:

Because both Rachel Benbow and Ian Thomas, both here after referred to as the "therapist," must be aware of existing medical conditions, I have stated all my known medical conditions and medications, and take it upon myself to keep the therapist informed about my updated physical health.

– I understand that the therapist cannot diagnose illness, disease, or any other medical, physical, psychological, or emotional disorder. I am responsible for consulting a qualified physician or medical practitioner for any physical/psychological ailments that I have.
– I understand that services offered by the therapist are not a substitute for medical care, and any information provided by the therapist is for educational purposes only and not diagnostically prescriptive in nature.
– I understand that Massage Therapy, CranioSacral Therapy and Reiki are therapeutic health aids.
– I understand that massage/bodywork is not appropriate care for infections or contagious illnesses or conditions. I will cancel my appointment as soon as I am aware of an infections or contagious illness or condition.
– I understand that the consumption of alcohol, recreational drugs, and pain killer pharmaceuticals can dangerously alter my body's ability to register and give feedback about pain or other vital sensations. Consumption of these items can also create detrimental and potentially deadly reactions when combined with massage/bodywork. I agree to NOT consume alcohol, recreational drugs or pain killer pharmaceuticals prior to any treatment sessions.
– I understand that post treatment soreness can occur by the evening following a treatment session, and may last into the next day. In a small percentage of cases, soreness can last up to three days. Discomfort following treatment may be in an area that was treated, or in another area that is connected through a fascial restriction. The body's tissues can experience discomfort during the post-treatment period due to release of restrictions and reorganization of the tissue. Drinking plenty of water and getting rest may help to minimize the temporary discomfort experienced following a treatment session.
– I understand that if I arrive late, my session will end at the originally scheduled time so the client following me is not penalized, and I will pay for the fully scheduled session.
– I agree to give 24-hour notice for a scheduled session that I cannot keep. I am aware that I may be charged the full fee for any missed sessions or for sessions that I do not give 24-hour notice to cancel or reschedule.
– I understand that the therapist is a volunteer responder for the CSMT Emergency Response Division, and that there may be rare occasions when the therapist may have to cancel and reschedule my session at short notice in order to assist at state or national emergencies/disasters.
– I understand that I will be charged, and agree to pay, a $2.75 processing fee when using a credit or debit card to pay for services or products. There are no additional fees for paying with cash or check.
– I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for the full payment of the scheduled appointment.
– I understand that I will not hold this establishment or therapist liable for anything related to this treatment.
– I agree to actively participate as much as possible in my own healing.

_____ _____

Client or Parent/Guardian Signature Date