



Today's Date: \_\_\_\_\_

Baby Information

Infant Name (First, Middle, Last) : \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parents Information

Mother's Name \_\_\_\_\_  Single  Married  Widowed  Divorced

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email \_\_\_\_\_

Father's Name \_\_\_\_\_  Single  Married  Widowed  Divorced

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email \_\_\_\_\_ If divorced or separated who has custody? \_\_\_\_\_

Responsible Party (if different from above)

Name (First, Middle, Last): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Responsible Party's Phone #: \_\_\_\_\_ Relationship to Infant: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Employer Phone: \_\_\_\_\_

Relative to Contact in Case of an Emergency

Name (First, Middle, Last): \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Chief Complaint

Please List: \_\_\_\_\_

Pregnancy

Complications: \_\_\_\_\_

Bedrest Y N \_\_\_\_\_

Trauma Y N \_\_\_\_\_

Meds Y N \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Labor

Gestation: \_\_\_\_\_ Spontaneous Induced

Vaginal C-Section: Planned Emergency

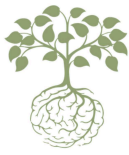
Location: Home Birth Center Hospital

Name of Hospital: \_\_\_\_\_

MW / OB \_\_\_\_\_ Doula \_\_\_\_\_

Labor \_\_\_\_\_ Pushed \_\_\_\_\_

Presentation: OA OP Breech



**How Were You Referred to Our Office?**

By An Attorney  By a Doctor  Print Ad  Online Directory  Search Engine  Marketing Event

Please Specify Source Here: \_\_\_\_\_

**Birth**

Birthday \_\_\_\_\_

Weight: \_\_\_\_\_ Length: \_\_\_\_\_ Head: \_\_\_\_\_

Apgar: \_\_\_\_\_ Spontaneous Respiration: Y N

Complications: \_\_\_\_\_

Nursery Stay: \_\_\_\_\_

**Nutrition**

Breastfeeding (Circle One): Latches Well Trouble Initiating Trouble Maintaining

Side Preference: L R Bi Symmetry Clicking: Y N

Appetite: Good Fair Poor \_\_\_\_\_

Solids Introduced: \_\_\_\_\_

Allergies: \_\_\_\_\_

**Digestion / Elimination**

Bowel Movement Frequency: \_\_\_\_\_ Consistency: \_\_\_\_\_ Color: \_\_\_\_\_

Constipation: Y N \_\_\_\_\_ Diarrhea: Y N \_\_\_\_\_

Straining: Y N Gassy: Y N Spitting Up: Y N Vomiting: Y N

**Growth/Sleep/Attitude**

Growth (Concerns if any): \_\_\_\_\_

\_\_\_\_\_

Sleep Pattern: \_\_\_\_\_

Night: \_\_\_\_\_ Naps: \_\_\_\_\_

Sleeps Soundly Y N Light Sleeper Y N

**Other**

Illnesses: \_\_\_\_\_

\_\_\_\_\_

Immunizations: None Delay/Selective Up-To-Date

Accidents: \_\_\_\_\_

Exposure to 2nd hand smoke: Y N

Comments: \_\_\_\_\_

## Questionnaire

1. Why are you here?
2. Has your baby had hands-on work before? When? With whom? What happened?
3. Does your baby seem comfortable in his/her body?
4. What was your baby's response to being born?
5. Cesarean? Forceps? Vacuum Extractor? Resuscitated? Intubated? NICU? Surgery?
6. How has your baby's weight gain been going since birth?
7. Has your baby been healing from circumcision?
8. Did you get antibiotics in labor?
9. Does your baby get diaper rash?
10. How is your baby's disposition?
11. What is your baby's sleep position?
12. If you are breast-feeding, do you have sore/injured nipples?
13. Does your baby prefer one breast or feeding position?
14. Does your baby favor turning his/her head to one side or the other?
15. Does your baby like "Tummy Time"?



**HIPAA Notice:**

I understand and agree to allow Myofascial & CranioSacral Therapies of Oklahoma to use my Patient Health Information for the purpose of treatment, payment, healthcare operation, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like a more detailed account of your policy and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA Notice that is posted for you at each one our locations before signing this consent If there is anyone you do not want to receive your medical records please inform our of-fice.

**Parent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Parent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Informed Consent for Infant Myofascial Release, Massage, Manual and Cranial Sacral Therapy:**

PLEASE PRINT CLEARLY:

I \_\_\_\_\_, certify that I am a parent or legal guardian of

\_\_\_\_\_ and grant permission for my child to receive myofascial release therapy, massage, manual and cranial sacral therapy from Myofascial & CranioSacral Therapies of Oklahoma. I have accurately filled out the Client Intake Form for my child that is going to be receiving the therapy services for any future dates with Myofascial & CranioSacral Therapies of Oklahoma. I am aware of the legal waiver that is in full effect with this signature for the person receiving the services as well as myself.

SIGNATURE OF PARENT or LEGAL GUARDIAN

If for any reason that you become non-eligible for the signing of this document for future dates you will submit in writing to Myofascial & CranioSacral Therapies of Oklahoma that information by a written letter in person to Myofascial & CranioSacral Therapies of Oklahoma.

**Parent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Parent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**\*\*\* IF POSSIBLE PLEASE BRING A BLANKET AND YOUR BABY’S FAVORITE ATTENTION GETTING TOY, IT WILL ASSIST WITH THE TREATMENT PROCESS \*\***