Today's Date: _____

Myofascial & CranioSacral Therapies of Oklahoma

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

Myofascial & CranioSacral Therapies of Oklahoma

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: _____

Myofascial & CranioSacral Therapies of Oklahoma

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"?

Myofascial & CranioSacral Therapies of Oklahoma

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 In-formation, 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 ****