## Infant/Baby Craniosacral Therapy Intake Wild Creek Healing Arts - Inna Dagman CMT

Client	Name: DOB:		
Paren	t/Guardian Name:		
Addre	SS:		
City/S	tate/Zip:		
Email			
Cell:	Referred by:		
	Gestation History		
•	Length of pregnancy (# of weeks)		
•	Did any of the following occur during pregnancy? A medications	Accidents New diagnosis	
If yes,	describe:		
	Labor/Delivery History		
•	How long was labor?		
•	How much time was spent pushing?		
•	Were you induced?		
•	Methods of pain control used?		
•	•	lormal Breech	
•	What type of delivery did your child have? Vaginal	C-Section	
•	Where was your baby born? Home Hospital		
•	Were forceps or suction used to assist in your child's	•	
	· · · · · · · · · · · · · · · · · · ·	-	
•	Did your child breathe on his/her own after being deli		
•	Were there any concerns with the umbilical cord during	•	
•	If yes, choose: loosely wrapped tightly wrapped	knotted	
•	Where was it wrapped?		
	Postnatal 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	
•	Was your baby diagnosed with lip/tongue tie?	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?		

	ical or adjusted vaccination schedu g describes your child's diet?	ule?
	lemand ula; Dairy based/ Dairy Free cerns you want to share about feed	ding your baby
	Family/Emotional Background	
Have there been any signific	If yes, what is the nature of the ant stressors/traumas in mom's/pa	rents' life since this baby was
How has mom's mood been	since the birth?	
Anything else you'd like to sh	nare about family dynamics & emot	tional and mental health
Priority concerns:	Additional Information List medications:	List and date surgeries:
Please initial each of the fo	_	_
<ul><li> I do not diagn</li><li> Payment for e</li><li> I understand t</li></ul>	ose or treat conditions, prescribe medicach session is due at the time of visit. hat I may be financially responsible for eled/changed within 48 hours prior to	r a missed or rescheduled
Signature/date:		