Sweet Pea Baby Clinic

By-Donation Cranial-Sacral Clinic for Pre-Crawling Babies

Child Intake Form

Your information will be kept confidential.
Email this TWO PAGE form to starbear@sonic.net along with your appointment sign-up sheet.

Childs Name: Birth Date: Weight: Age:

Parent's Names:

Phone: W: H: C: email:

Address: City/State

REASON FOR THIS VISIT:

DURING PREGNANCY: Was baby planned? YES___ NO___
Were in-vitro conception, and other assisted reproductive technologies used? YES___ NO___ If yes, please explain…

Any medication taken by mom? If yes, what: _____

Smoking/Alcohol? YES___ NO___ If yes, how much? _____

Were there any significant events, losses, stresses, or traumas for mom or baby? Please explain:

LABOR:
Did you have a Home Birth/Hospital/Birth Center Birth?

Was labor induced? YES ___ NO ___ How long was labor? _____

Were labor drugs used? YES___ NO___ If yes, explain:

Forceps/Vacuum Extraction? YES ___ NO___

Cesarean Birth? YES___ NO___ Planned or Emergency?

Was baby premature? YES___ NO___ How early? _____

Neonatal Intensive Care? If yes, how long? _____

Tell us about any problems or issues during birthing or shortly after:

POST PARTUM:
Any issues with feeding? YES___ NO___ If yes, tell us more:

Please Note: YOUR SESSION MAY BE FILMED FOR EDUCATIONAL AND TRAINING PURPOSES AND MAY BE USED BOTH WITHIN, AND OUTSIDE OF, THE CLINIC. Thank you for supporting us in furthering this work!

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How is baby sleeping?

Were you and baby separated at, or after, birth? If yes, how long and why:

Any other issues you need support with?

How connected do you feel to your baby (circle, or indicate, one number on the scale)?

(not connected) 0 1 2 3 4 5 6 7 8 9 10 (fully connected)

DESCRIBE THE REASON FOR YOUR VISIT TO Sweet Pea Baby Clinic**:**

HOW DID YOU HEAR ABOUT Sweet Pea Baby Clinic**?**

ANYTHING ELSE YOU WANT US TO KNOW? (Continue on an additional sheet if necessary)

Are you familiar with Cranial Sacral Therapy? _____

_____

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