Therapy Roots, LLC
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Infant Intake

Child's name:_____

DOB: _____ Age: _____ Today's Date: _____

Parent(s): _____

Phone: _____ E-Mail: _____

Other Providers: _____

PCP/MD: _____

Gestation History

- Length of pregnancy (# of weeks) _____
- Did any of the following occur during pregnancy?
  - ☐ Accidents
  - ☐ New Diagnosis
  - ☐ Medications
  - ☐ Stressful Event
  - ☐ Emotional Regulation
- If yes, describe:

Labor/Delivery:

- How long was labor? _____
- How much time was spent pushing? _____
- Were you induced? YES NO
- Which pain methods of pain control were used? _____
- What was the baby's presentation at birth?....Normal.....Breech.....FaceUp.....LOA

- What type of delivery did your child have.....Vaginal.....C-Section.....
    - If C-Section, was it planned or an emergency?
- Were forceps or suction used to assist in your child's delivery? YES NO
- Did your child breathe on his/her own after being delivered? YES NO
    - If no, what interventions were taken?
- Were there any concerns with the umbilical cord during birth? YES NO
- If yes, choose: loosely wrapped.....tightly wrapped.....knotted.....nuchal cord
- Where was it wrapped: _____
- Was your baby in Intensive Care: YES NO
- Is your baby breast fed? YES NO
- Does your baby struggle with feeding? YES NO
- Does your baby spit up frequently? YES NO
- Does your baby have colic? YES NO
- Does your baby have regular bowel movements? YES NO
- Does your baby have strabismus (lazy eye)? YES NO
- How does your baby sleep? _____
- Has he/she had a typical vaccination schedule? YES NO
- Does your baby feel tight? YES NO
- Does your baby gag frequently? YES NO
- Does your baby use a pacifier? If so, what type: _____
- Is your baby swaddled? YES NO
- Is your baby circumcised? YES NO N/A

- Has your baby been diagnosed with tongue tie, lip tie, buccal ties?
    - Has there been a release? Date:

- Priority Concerns: _____

_____

Medications/Supplements: _____

_____

Hospitalizations or surgeries: _____

_____

Anything else you would like to add (comments, questions, ...): _____

_____

_____

_____

Please read and initial each of the following and sign at the bottom:

1. _____I give my consent for my baby to receive Biodynamic Craniosacral Therapy.

2. _____I give my consent for my baby to receive Speech Therapy

Parent/Guardian signature: _____ Date: _____

Parent/Guardian name (print): _____