GROUNDSWELL MFR

INFANT INTAKE FORM

Today's date: _____

Patient's name: (print)_____ (initials) _____ (nickname) _____

Family members: _____

Date of birth: _____ Age: _____

Parent(s)/Guardian's name: _____ Parent(s)/Guardian's signature: _____

Address: _____

Mobile Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____

Sex: _____Male _____Female Height: _____ Weight: _____

Physician(s): _____ Phone: _____

How did you hear about us? _____

What are your hopes and goals for your child through Myofascial Release?

_____
_____
_____
_____
_____
_____

Please list and describe any and all challenges, difficulties, and/or symptoms (including the location, intensity, quality, etc.) which are keeping your baby from living her/his best life:

_____
_____
_____
_____
_____
_____

Please list your primary concerns:

_____
_____
_____
_____

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GESTATIONAL HISTORY

Length of Pregnancy (i.e. # of weeks): _____

Please share any significant or noteworthy events, and mark if any of the following occurred leading up to/during pregnancy:
____ Accident(s)
____ New diagnosis
____ Medications
____ Stressful event
____ Other:
_____

If yes to any of the above, please describe
_____
_____
_____
_____
_____
_____
_____

Labor/Delivery History:
How long was labor? _____

How much time was spent pushing? _____
Were you induced? _____

What methods of pain control were used? _____

What was your baby's presentation at birth? ____ Normal. ____ Breech. ____ Other _____

What type of delivery did your child have? ____ Vaginal. ____ C-section. ____ Other _____

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
_____

Were there any concerns with the umbilical cord during the pregnancy/birth? ____ Yes (loosely wrapped, tightly wrapped, location) _____. ____No.

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POSTNATAL HISTORY

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 activity? __Yes. __ No.

How does your baby sleep? __Yes. __ No.

Has he/she had a typical vaccination schedule? __Yes. __ No.

Does your baby feel tight? __Yes. __ No.

Has your baby been diagnosed with tongue/lip tie? __Yes. __ No.
If yes, has it been revised?
_____

Past Medical and Surgical History: Please list any and all diagnoses, conditions, accidents, traumas, surgeries and/or procedures (from birth to present, and approximate date)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Social or Family History that may influence your child's current state:

_____

_____

_____

_____

Medications: (Please list current/past medications, supplements, herbs)

Medication	For the Treatment of	Dose of Frequency	Effectiveness