Intake Form: Balanced Baby Clinic

This information will help us best care for you and your baby

Parent Name :_____ Age:_____

Baby Name :_____ Age:_____

Presenting Complaint and/or Concerns:

☐ fussy/gassy baby ☐ excessive crying ☐ breast refusal ☐ feeding difficulties ☐ structural issues ☐ preemie ☐ twins
Other:_____

Conception History: ☐ natural ☐ IVF ☐ IUI ☐ Surrogate ☐ Adoption

Labor History:

Place of Delivery: _____ Gestation @ Birth: _____

Type of Delivery:

☐ Vaginal ☐ C-Section ☐ Induction ☐ Scheduled C-Section ☐ Pitocin ☐ Epidural ☐ Vacuum Extraction ☐ Forceps
☐ cord wrapped Total Length of Labor: _____ How long did you push? _____

Complications: ☐ None ☐ Yes, specifically: _____

Baby:

☐ Boy ☐ Girl Birth weight: _____ Current weight:_____ Any weight gain issues? ☐ yes ☐ no

Temperament: (rate on a scale of 1 = overall happy to 10 = mostly unhappy) _____

Easily agitated: ☐ yes ☐ no **Cries intensely?** (rate on a scale of 0 = not intense to 10 = very intense) _____

Have you been told the baby has reflux? ☐ yes ☐ no If so, medicated? ☐ yes ☐ no

How does the baby look/feel structurally?
☐ misshapen head ☐ tight/stiff arms or legs ☐ floppy ☐ clenched fists ☐ arching ☐ flexed hips (legs pulled in)
☐ head tilt (one side)

Sleep: ☐ sleeps well ☐ doesn't sleep much ☐ falls asleep but doesn't stay asleep

Have you been told that your baby has a lip and/or tongue tie? ☐ No ☐ Yes
If so has it been released? ☐ No ☐ Yes **By who? _____**

Currently feeding: ☐ breast ☐ bottle ☐ pumping ☐ formula ☐ expressed breast milk

Parent:

How many Children?_____

How do you feel? ☐ normal ☐ anxious ☐ stressed ☐ depressed

Any specific physical complaints?

_____
_____
_____
_____
_____

The Balanced Baby, LLC
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DISCLOSURES TO INDIVIDUALS AND HIPAA PRIVACY AUTHORIZATION FORM

There may be times when it is necessary for an individual involved in your care to call us to inquire about your personal health information or billing information. Please take a few moments to complete this section.

I authorize **Alyssa Frey, M.S., OTR/L, LLC and/or Maria Parlapiano RN IBCLC of The Balanced Baby LLC** to use and disclose my health information that is related to my current treatment to, (please indicate name, relationship, and other relevant information):

1._____
2. _____
3. _____
4. _____
5. _____

This authorization for release of information covers all past, present, and future periods.

☐ **I authorize the release of my complete health record.**

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature: _____

Relationship to client (please specify self, parent, guardian, other): _____

Date: _____