Natural Balance
INTEGRATIVE CARE

Today's Date: ______________

Baby Information

Infant Name (First, Middle, Last) : ____________________ Date of Birth:____________

Parents Information

Mother's Name ____________________ ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Address:____________________City, State, Zip: ____________________

Home Phone: ____________Cell Phone: __________Work Phone:______________

Email____________________

Father's Name ____________________ ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Address:____________________City, State, Zip: ____________________

Home Phone: ____________Cell Phone: __________Work Phone:______________

Email____________________ If divorced or separated who has custody? __________

Responsible Party (if different from above)

Name (First, Middle, Last):____________________ Date of Birth:____________________

Address:____________________ City, State, Zip:____________________

Responsible Party's Phone #:____________________ Relationship to Infant: ______________

Occupation:______________ Employer:____________ Employer Phone:______________

Relative to Contact in Case of an Emergency

Name (First, Middle, Last): ______________Phone:__________ Relationship to Patient:__________

Address:____________________ City, State, Zip:____________________

Chief Complaint

Please List: ____

____

Pregnancy

Complications:____________________

Bedrest Y N ____________________

Trauma Y N ____________________

Meds Y N ____________________

Comments: ____________________

____

____

Labor

Gestation:____________ Spontaneous Induced

Vaginal C-Section: Planned Emergency

Location: Home Birth Center Hospital

Name of Hospital: ____________________

MW / OB__________ Doula__________

Labor__________ Pushed____________

Presentation: OA OP Breech

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How Were You Referred to Our Office?

☐ By An Attorney ☐ By a Doctor ☐ Print Ad ☐ Online Directory ☐ Search Engine ☐ Marketing Event

Please Specify Source Here:____

Birth

Birthday________________

Weight: _________________ Length: ________________ Head: _____________________

Apgar;____________________ Spontaneous Respiration: Y N

Complications:____

Nursery Stay:____

Nutrition

Breastfeeding (Circle One): Latches Well Trouble Initiating Trouble Maintaining

Side Preference: L R Bi Symmetry Clicking: Y N

Appetite: Good Fair Poor __________________________________

Solids Introduced: _______________________

Allergies: ____________________

Digestion / Elimination

Bowel Movement Frequency: ______________________ Consistency: ____________ Color: ___________________

Constipation: Y N _______________ Diarrhea: Y N ___________________

Straining: Y N Gassy: Y N Spitting Up: Y N Vomiting: Y N

Growth/Sleep/Attitude

Growth (Concerns if any): ________________________

____

Sleep Pattern: __________________________________

Night: __________________ Naps:_________________

Sleeps Soundly Y N Light Sleeper Y N

Other

Illnesses: ____________________________________

____

Immunizations: None Delay/Selective Up-To-Date

Accidents: ___________________________________

Exposure to 2nd hand smoke: Y N

Comments: ___________________________________

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Questionnaire

1. Why are you here?

2. Has your baby had hands-on work before? When? With whom? What happened?

3. Does your baby seem comfortable in his/her body?

4. What was your baby's response to being born?

5. Cesarean? Forceps? Vacuum Extractor? Resuscitated? Intubated? NICU? Surgery?

6. How has your baby's weight gain been going since birth?

7. Has your baby been healing from circumcision?

8. Did you get antibiotics in labor?

9. Does your baby get diaper rash?

10. How is your baby's disposition?

11. What is your baby's sleep position?

12. If you are breast-feeding, do you have sore/injured nipples?

13. Does your baby prefer one breast or feeding position?

14. Does your baby favor turning his/her head to one side or the other?

15. Does your baby like "Tummy Time"?

HIPAA Notice:

I understand and agree to allow ***Natural Balance LLC*** to use my Patient Health Information for the purpose of treatment, payment, healthcare operation, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like a more detailed account of your policy and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA Notice that is posted for you at each one our locations before signing this consent If there is anyone you do not want to receive your medical records please inform our office.

Parent Signature: ____________________________Date: _____________________

Parent Signature: ____________________________Date: _____________________

Informed Consent for Infant Myofascial Release, Massage, Manual and Cranial Sacral Therapy:

PLEASE PRINT CLEARLY:

I ______________________________, certify that I am a parent or legal guardian of

________________________________ and grant permission for my child to receive myofascial release therapy, massage, manual and cranial sacral therapy from Natural Balance. I have accurately filled out the Client Intake Form for my child that is going to be receiving the therapy services for any future dates with Natural Balance. I am aware of the legal waiver that is in full effect with this signature for the person receiving the services as well as myself.

SIGNATURE OF PARENT or LEGAL GUARDIAN

If for any reason that you become non-eligible for the signing of this document for future dates you will submit in writing to Natural Balance that information by a written letter in person to Natural Balance.

Parent Signature: ____________________________Date: ___________________

Parent Signature: ____________________________Date: ___________________

***** IF POSSIBLE PLEASE BRING A BLANKET AND YOUR BABY'S FAVORITE ATTENTION GETTING TOY, IT WILL ASSIST WITH THE TREATMENT PROCESS ****