Anne Cartegnie, LLC.

CRANIOSACRAL & BIRTH-AND-PRENATAL THERAPY

Client Information Form - Child Intake form

CONFIDENTIALITY: All information on this questionnaire will be kept strictly confidential.

Date: _____ - Who referred you? _____

Child Name: _____ Age: _____ Birth Date: _____

Mother's Name: _____ - Age: _____
E-mail _____ - Phone: _____

Father's Name: _____ - Age: _____
E-mail _____ - Phone: _____

Parents are: ❑ Married ❑ Unmarried ❑ Live together ❑ Live separately

Any sibling? _____

❑ Yes ❑ No Has your child previously experienced Craniosacral Therapy?

❑ Yes ❑ No Has mom previously experienced Craniosacral Therapy?

❑ Yes ❑ No Has dad you previously experienced Craniosacral Therapy?

Current physical, developmental or academic challenges for the child:

_____
_____
_____
_____

Current emotional/relationship challenges for the child:

_____
_____
_____
_____

Primary concerns of parents, intention in having sessions:

_____
_____
_____
_____

PRECONCEPTION OF YOUR CHILD:

Did either mom or dad lose a child through miscarriage, abortion, early death, or adoption prior to this pregnancy?? ❑ Yes ❑ No

If yes, please describe circumstances, dates, age of fetus or child at time of loss. Have you grieved this loss? How did it affect this pregnancy?

Did any stressful event happened in the family before conception? ❑ Yes ❑ No

CONCEPTION OF YOUR CHILD:

❑ planned ❑ unplanned ❑ wanted ❑ unwanted ❑ confused

Was there any stress and/or any other issue related to conception? ❑ Yes ❑ No. If yes please describe:

Did you use assisted reproductive technology? ❑ Yes ❑ No:

Any drugs or alcohol at the time of conception? ❑ Yes ❑ No. If yes please describe:

DISCOVERY:

How was it for mom and dad to discover the pregnancy?

Was abortion considered? ❑ Yes ❑ No

Attempted? ❑ Yes ❑ No. If yes, please describe, including when this was during the pregnancy.

PREGNANCY:

How was mom's health during the pregnancy? Please include health challenges, diet, exercise, and attitude toward being pregnant.

Any medications used during pregnancy? ❑ Yes ❑ No

What was dad's role and attitude during pregnancy? Was he supportive of mom? If so, how?

What was your support system like, including parents, family, friends, etc. and their attitudes toward the pregnancy?

What was mom's and dad's relationship like?

Did either mom or dad smoke, drink alcohol or use recreational drugs? If yes, who, what, how much, and how often? How does this compare to current use?

Did mom and dad experience any stresses during the pregnancy? (e.g. illness or death of a friend, parent or other family member; depression or mental illness, financial worries, change in job or residence, lack of support from family or friends, strained relationship between mom and dad)? Please describe.

BIRTH:
Did the birth occur at:
❏ home ❏ birth center ❏ hospital ❏ other:_____

Who was at the birth? What were their roles and relationships with mom and dad?
_____
_____
_____

Any drugs used during labor? ❏ Yes ❏ No. If yes please describe:
❏prolonging pregnancy ❏ induction ❏ anesthesia ❏ epidurals ❏ other:_____
Include the reason for use:
_____
_____
_____

Any interventions? ❏ Yes ❏ No. If yes please describe:
❏ induced ❏ forceps ❏ vacuum extraction ❏ Episiotomy Other:_____
❏ C-section (planned, emergency, why?) Describe your experience.
_____
_____
_____

Birth Weight: ❏ low ❏ normal ❏ heavy - ❏ Tear: _____

Other birth complications or concerns?
_____
_____
_____

FIRST HOUR/DAYS AFTER BIRTH:
Where was your baby the first hour after birth?
❏ with mom ❏ nursing ❏ separated for washing measuring, testing, ❏ intubation
❏ other: _____
After the first hour, was baby with mom or dad most of the time? ❏ Yes ❏ No

If separated, how long, and why?
_____
_____
_____

NICU? ❏ Yes ❏ No. If yes, how long, reason for being there, procedures used. How was this time for you?
_____
_____
_____

POSTPARTUM:

Nursing? ❑ Yes ❑ No. How long? _____ How was it for you? Any difficulties, complications?

_____
_____
_____

What kind of support did you have the first few months after the birth?

_____
_____
_____

How was mom and dad's relationship after the birth?

_____
_____
_____

How was dad's relationship with baby after the birth?

_____
_____
_____

Please describe any postpartum or later health complications, illnesses for baby or mom, including postpartum depression. How were these treated? How long did they last?

_____
_____
_____

Circumcision? ❑ Yes ❑ No. Any complications? _____

Vaccinations? ❑ Yes ❑ No. When? Any complications?_____

Anything else you want me to know or have concerns about?

_____
_____
_____
_____
_____
_____

Please read carefully and initial:

_____ I understand that the CranioSacral therapist does not diagnose illness, disease, or any other physical or mental disorder. CranioSacral therapy is not a substitute for medical examinations and/or diagnosis. It is recommended that we see a physician for any physical ailment which concerns us.

_____ I understand that craniosacral therapy is considered by some to be a contraindication for recent injuries to the head and neck.

_____ I agree to keep the therapist updated as to any changes in my medical profile during the sessions.

_____ Some people may experience mild discomfort after a treatment. This may be due to re-experiencing a trauma or injury or a previously numb area may come back to life and be more sensitive. If this happens, clients can experience some emotions and sensations that may be uncomfortable or challenging to experience.

_____ I release the therapist from responsibility and liability for any adverse reactions resulting from disclosed and undisclosed conditions.

_____ Please note that, since I have reserved our appointment time for you, it is my policy to charge for cancellations received with less than 24 hours notice.

Parent's signature (or legal guardian) _____ Date: _____

Parent's signature (or legal guardian) _____ Date: _____

I have completed the above information accurately and have read, understand, and take responsibility for the above statements.