Last Name of Parent: _____

CFT Infant Intake

Date: _____

Child's name: _____ DOB: _____ Age:

_____

Parent/Guardian Name:

_____

Phone: _____ E-mail:

_____

Is it ok to leave messages at above number?: _____

Gestation History:

- Length of pregnancy (weeks): _____
- Did any of the following occur during pregnancy?
  - Accidents
  - New diagnosis
  - Medications
  - Stressful events

If yes to any of the above, please describe here:

_____

_____

_____

_____

_____

Labor & Delivery:

Last Name of Parent: _____

- How long was labor? _____
- Time spent panting and pushing? _____
- Were you induced? YES / NO
  - Which methods of pain control were used? _____
  - What was baby's presentation at birth? Normal / Breech
  - What type of delivery? Vaginal / C-section
  - 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 birth? YES / NO
    - If so, choose: loosely wrapped / tightly wrapped / knotted
    - Where was it wrapped? _____

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 colic? YES / NO
- Does your baby have regular bowel activity? YES / NO
- Does your baby have strabismus (lazy eye)? YES/NO
- How is your baby's sleep? _____
- Does your baby feel tight? YES / NO
- Does your baby gag frequently? YES / NO
- Does your baby use a a pacifier? YES / NO
  - If yes, what type? _____

Last Name of Parent: _____

- Is your baby swaddled? YES / NO
- Has your baby been diagnosed with tongue / lip / buccal ties?
  - If so, have they been released? YES / NO
    - If yes, date: _____

Hospitalizations:

Medications:

Priority Concerns:

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

_____ I give consent for my baby to receive treatment from Whitney Shepperd, OTR/L

_____ I understand Whitney Shepperd, OTR/L does not accept insurance but can provide me with a receipt to submit to insurance upon request.

_____ Whitney Shepperd is not able to diagnose, treat conditions or prescribe medications.

Last Name of Parent: _____

Parent/Guardian: _____

Date: _____