Gina M. Baker, CMT

CranioSacral Therapy ~Restorative Bodywork ~ Yoga/Meditation

Today's Date _____

Child Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

Phone (home) _____ (work/cell) _____ email _____

Occupation _____ Height _____ Weight _____

Emergency contact name & number _____ Referred by: _____

Are you currently in pain or experiencing any discomfort? If so, please briefly explain and indicate those areas below _____

_____

BIRTH STORY:

_____

_____

_____

_____

_____

_____

_____

CURRENT COMPLAINTS:

_____

_____

_____

_____

_____

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_____

MEDICATIONS/SUPPLEMENTS/HOMEOPATHICS:

_____

_____

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_____

OTHER TREATMENTS:

_____

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_____

_____

_____

BABIES RESENT HISTORY:

YES ____ NO____ Spitting Up
YES ____ NO____ Digestion Issues
YES ____ NO____ Tendency to look to one side
YES ____ NO____ Sleep Issues
YES ____ NO____ Feeding Issues
YES ____ NO____ Birth Issues

- I understand the treatment here is not a replacement for medical care.
- As such, the therapist/practitioner does not prescribe medical treatment of pharmaceuticals, nor does he/she perform any spinal manipulations (unless specified under his/her professional scope of practice)
- I understand that the treatment is not a substitute of medical treatments and/or diagnosis and it is recommended that I see a qualified professional for any physical or mental conditions that I may have.
- I have stated all known conditions and take it upon myself to keep the therapist/practitioner updated on my baby's health.
- I understand that payment is due at the time of treatment unless arrangements have been made otherwise.
- **I agree to give at least 24 hours notice of cancellation of appointment, otherwise will be expected to pay for session PLEASE INITIAL _____**

Parent or Guardians signature_____Date_____