CRANIOSACRAL & HISTORY FORM

CLIENT NAME: _____

BIRTHDATE: _____ MALE / FEMALE (CIRCLE)

PLEASE CIRCLE OR FILL IN APPROPRIATE AREA:

1. PREGNANCY HISTORY:

- Did mother have high fevers during pregnancy? Y N

  If YES, explain length, reason, frequency: _____

  _____

  _____

- Did mother use medications during pregnancy? Y N

  If YES, please explain and list medications: _____

  _____

  _____

- Did mother have any health problems including back problems during pregnancy? Y N

  If YES, please explain: _____

  _____

- Did mother smoke during pregnancy? Y N
- Did mother use drugs or alcohol? Y N

  If YES, please describe: _____

2. BIRTH HISTORY:

- Was baby full-term? Y N

  If NOT full term, how many weeks old? _____

- How long was birth phase? _____hours.
- Were any of the following used:

  Vaccuum extraction Y N

  Ptocin Y N

  Forceps Y N

  Cesaerian Section Y N

  Cord Around Neck Y N

  Other: _____

- What condition was the infant upon delivery? _____

_____

3. INFANT SYMPTOMS:

- Did your infant have any of these symptoms? **If YES, please elaborate:**

Sleep disturbance? Y N _____

Abnormal Crying (too much or can't)? Y N _____

_____

Sucking disturbance, including sucking only one breast? Y N _____

_____

Vomiting-pyloric stenosis (entry into stomach is constricted)? Y N _____

Colic? Y N _____

Developmental Delay? Y N _____

Seizures? Y N _____

Srabismus (squinty/crossed)? Y N _____

Nystagmus (involuntary rapid movement)? Y N _____

Irritable Baby? Y N _____

Baby who wants constant holding? Y N _____

Digestive Disturbances? Y N _____

Other: _____

4. CHILD SYMPTOMS: DOES YOUR CHILD HAVE ANY OF THESE SYMPTOMS? **If YES, please elaborate:**

- Learning disabilities? Y N _____
- Tongue Thrust? Y N _____
- Speech disorders? Y N _____
- Behavior Disorders (constant irritation to CNS)? Y N _____

_____

- Lack of sensory integration (too much stimulous and unable to process effectively? Y N

_____

- Middle ear problems including frequent ear infections? Y N _____

_____

- Enurisis (bedwetting)? Y N _____

- Scoliosis? Y N _____
- Postural Dysfunction (such as low muscle tone in trunk)? Y N _____

  _____
- Toe Walking? Y N _____
- Children that aren't growing related to pituitary function? Y N _____

  _____
- Miserable Child Syndrome (grouchy, less coordinated, upset easily), food allergy? Y N

  _____
- Hyperkinesis? Y N _____
- Does or did child have braces? Y N For how long?_____
- Did child have any significant falls, accidents? Y N _____

  _____

  _____
- Did child have any high fevers, significant illnesses, infections? Y N

  Please describe: _____

  _____

FILLED OUT BY: _____ DATE: _____

RELATIONSHIP TO CLIENT: _____