

Jeremy Manalis, LMT, VCSW • Craniosacral Therapy for Babies

Child's Name _____ Birth Date _____ Today's Date _____

Address _____

City _____ State _____ Zip _____

Caretaker's Name _____

Phone: (H) _____ (W) _____ (C) _____

Email _____ Occupation _____

Has your child received Alternative health care in the past? (circle one) Yes No

Specialty: _____

Please describe the reason for previous care: _____

Name of your Medical Doctor: _____

What other health care providers are you and/or your baby seeing, and their specialty?

How do you hope your child will benefit from receiving Craniosacral Therapy?

Please rank current & ongoing problems by priority and then complete the following:

Describe Problem, Date, Mild/Mod/Severe, Treatment, & Approach Success
(Example: Exccema, Jan'06, Moderate, Diet & Steroid cream, Moderate)

1. _____
2. _____
3. _____
4. _____
5. _____

In general, would you say your child's health is - check one:
Excellent Very Good Good Fair Poor

The Birth (circle those that apply)

Vaginal Breech Forceps Vacuum extraction
Home Birth Hospital Birthing Centre

Cesarean If yes, for what reason was a cesarean section performed:

Pregnancy problems:

Labor or delivery problems:

Congenital Defects / Anomalies:

Was the infant alert and responsive within twelve hours of delivery? Yes No

Birth length: Birth weight:

Has or was this child been breastfed? Yes No

If yes, please provide details. (i.e. explain for how long, any difficulties, etc.):

CONSENT TO TREAT A MINOR

I, _____ (parent/guardian) give my permission to Jeremy Manalis, LMT
for _____ (child's name) _____ (DOB) to
give Craniosacral Therapy.

This _____ day of _____ 20_____

Signature _____ Date _____