ELIZABETH ROSE
lifestyle & integrative wellness

INFANT CFT INTAKE FORM

Child's Name_____ Date of Birth_____ Age_____

Parent / Guardian Name(s) _____

Address _____

City _____State _____Zip _____

Phone _____ Email _____

Primary physician _____

Gestation History

Length of pregnancy (# of weeks) _____

Did any of the following occur during pregnancy? ___ accidents ___ new diagnosis ___ medications ___ stressful event ____ illness

If yes, please describe _____

Labor/Delivery History

Where was the child born? Hospital, home, birth center? _____

How long was labor? _____

How much time was spent pushing? _____

Were you induced? _____

How was the child born? _____ Vaginal _____ Cesarean

If vaginal, what was the child's presentation? Breech, face up, face down _____

Were forceps or suction used to assist in the delivery? _____

Were there any concerns with the umbilical cord? Tightly wrapped, loosely wrapped, knotted? _____

_____

Postnatal History

Was your baby in intensive care? YES NO

Is/was your child breastfeed? YES NO

If yes, for how long? _____

Does your baby struggle with feeding/latch? YES NO

Does your baby spit up frequently? YES NO

Is your baby unusually fussy? YES NO

Have you been told your baby has colic? YES NO

How often does your baby poop? _____

How does your baby sleep? Swaddled? Mouth open or closed? _____

Where does he/she sleep? _____

Has your baby had a typical vaccination schedule? YES NO DELAYED

Has your baby been diagnosed with a tongue/lip tie? YES NO

If so, has it been revised? _____ Date _____ Provider _____

Is your baby currently or has your baby previously received support from any other services? (lactation, chiropractor, physical therapist, occupational therapist, speech, myofunctional therapist,etc.)

_____

_____

At what age did your baby reach these developmental milestones:

Milestone	Approximate Age
Rolling	_____
Sitting	_____
Crawling	_____

Please list any medical diagnoses, hospitalizations, surgeries or injuries

_____

_____

Does your child take any medications or supplements? If so please list them

_____

_____

Any allergies? __ Yes __ No

If yes, please list _____

Does your child have any siblings? If so what is/are their name(s) and age(s) _____

_____

What is your priority concern and goal for treatment?

_____

Anything else you wish to tell us about or not wish to discuss in front of your baby?

_____

_____

Gillespie Approach-Craniosacral Fascial Therapy (CFT) is a gentle, non-invasive healing modality that provides patients with a freely moving brain, spinal cord, and fascial web, all of which are critical to peak health. While there is minimal risk in receiving CFT, individuals receiving therapy may experience adverse side effects or harm either temporary or permanent. It is recommended you consult with your child's physician prior to receiving any therapy. CFT is not intended to replace other forms of health care and it is used as a form of adjunctive care only.

I attest that any and all information I have provided is true, and accurate to the best of my knowledge. I understand that treatment notes will be kept for treatment purposes only. This record, along with my child's personal information will be kept confidential and will not be released to others unless so directed by myself or unless law requires it.

I also understand that I am expected to notify my provider, if there are any changes to my child's health, or if I am uncomfortable with any part of my child's CFT sessions. I understand results are not guaranteed. I do not expect that the provider will be able to anticipate and explain all risks and complications.

With this knowledge, I voluntarily consent to the therapeutic treatment mentioned above. I intend this consent form to cover the entire course of treatment with Elizabeth Rose Lifestyle and its associated providers. I understand I am free to withdraw my consent and to discontinue participation in treatment sessions at any time.

I, as the legal parent/guardian of, _____ give consent for my child to receive craniosacral fascial therapy (CFT).

Parent/guardian signature _____ Date_____

Printed name _____ Relationship _____

Photo Release

I authorize Elizabeth Rose Lifestyle the right to photograph and/or video record myself and/or my child, use the photo and/or video of him/her/myself in any and all of its publications and in any and all other media (e.g. Facebook, Instagram, website, magazines, etc.), whether now known or hereafter existing. I understand and agree that these materials will become the property of Elizabeth Rose Lifestyle. Additionally, I waive any right to any compensation arising or related to the use of the photograph or video. I release Elizabeth Rose Lifestyle, and its contractors, from liability for any claims by me or any third party in connection with my participation and/or use of the photograph/video. By signing below, I have read, understand, and agree to the above photo/video terms for myself and/or are in fact the parent and/or legal guardian of the listed child.

I consent _____
I DO NOT consent _____

_____ _____
Client Signature Date