Huddersfield Osteopathy

Baby Patient Information Form

Consultation date / /

Childs Surname		Childs First Name
DOB	Age	Sex: ☐ Male ☐ Female
Parent's names		

Address Line 1 Line 2 Line 3 Line 4 Line 5 Post Code	Mobile Phone Other Phone Email *Please tick if you would like to receive our newsletter and email offers* ☐
GP Name and practice address GP phone number	Have you seen your GP about this issue? ☐ Was medication prescribed? ☐ *Please tick if you give consent for your osteopath to contact your GP & provide details of treatment and findings. They will discuss the reasons why if this is necessary* ☐

How did you hear about us?

☐ Internet ☐ Referral Friend / Family - *would you mind saying who?*
☐ Facebook ☐ Referral other - *if so, from who?*
☐ GP Referral ☐ Other - *please provide details*

I agree that all information contained in this form is correct at this time.
I agree to be responsible for all fees and have been informed of said fees.

_____

☐ Parent / ☐ Guardian

Thank you – Please fill in the next section – this helps your osteopath to understand your babies symptoms

Reason for visit

PREGNANCY & PREGNANCY HISTORY

Babies movements in utero	Prenatal complications for this pregnancy
Babies preferred position in utero	
Number of previous pregnancies	

LABOUR & BIRTH

Delivery

- ☐ Natural / vaginal
- ☐ Induced
- ☐ Elective C-Section
- ☐ Emergency C-Section
- ☐ Forceps
- ☐ Ventouse
- ☐ Episiotomy

Duration of labour

1st stage _____

2nd stage _____

3rd stage _____

Analgesia

- ☐ Pethidine / Diamorphine / Remifentanyl / Meptid/
- ☐ Gas & Air
- ☐ Tens
- ☐ Epidural
- ☐ None
- ☐ Other (details below)

Gestation	Babies birth weight	Please provide details of any birth complications
Babies birthing position / presentation		
Mothers birthing position		
APGAR 1min	APGAR 5mins	

POST NATAL

Stay in hospital	Please provide details of any post birth complications
Bruising / moulding	
Alertness	
Breathing / Crying	
Settling / Sleeping	

Please provide details of how your babies weight is progressing

FEEDING

Current feeding method

- ☐ Breast-feeding
  - *Favoured side?* ☐ *L* ☐ *R*
- ☐ Expressing bottle-fed
- ☐ Formula bottle-fed

FEEDING PRESENTATION

Does your baby do any of the following whilst feeding?

- ☐ Clicking
- ☐ Recurrent pulling away
- ☐ Short feeds
- ☐ Dribbling
- ☐ Pain whilst feeding *(if breast fed)*

If using formula, which are you using? Which have you tried?	Please provide details of any feeding pain or issues / complications *(OPTIONAL: If you stopped breast-feeding, please provide details)*

GENERAL HEALTH ISSUES

E.g. Bladder/ bowel / stomach / abdomen / circulation / breathing / restricted movements / accidents / illness / operations