Brenda Barnetson, CMT * *The Touch of Health* * 818-892-5192
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CranioSacral Therapy Client Information - **CHILD**

Child's Name _____ Birthdate _____Age ____ Today's Date _____
Street Address _____ City _____ State _____ Zip _____
Mother's Name _____ Father's Name _____
Mother's Work Phone _____ Father's Work Phone _____
Home Phone _____ Cell Phone _____Referred by: _____
Email: _____
Reason for bringing your child today? _____
_____
Any accidents, injuries, or surgeries? No ____ Yes ____ If yes: _____
_____

Birth and Infancy History:

____ Caesarian delivery?
___ Labor difficulties?_____
____ Breast fed or ____ Bottle fed?
____ Severe colic or sucking problems?_____
____ Ear inflammations/infections?
___ Forceps or vacuum suction delivery?
____ Anesthesia/epidural? _____
____ Vaccinations? _____
____ Pacifier use? How long? _____
____ Frequent illnesses? _____

Health History:

____ recent dental work
____ orthodontia/braces
____ TMJ problems
____ headaches
____ mouth breather ___day ___ night
____ snores
____ allergies _____
____ sleeps through the night
____ bed wetter
____ asthma or respiratory problems
____ specific medical condition?_____
____ childhood illnesses
____ difficulty falling asleep

School situation: Please describe your child's experience at school. Able to focus? Fidgety? Has friends?

_____
_____

Nutritional habits: # vegetables per day ____ # fruits per day ____ whole grains ____
meat & chicken? ____ fish? _____ Water: :oz. per day?_____ supplements? _____
Good appetite? _____ Prefers sweet or salty? _____

Personal habits: Television? Hours/week ____Computer/Video Games? Hours/week _____
Movies/videos? Hours/week _____ Bedtime at ____pm Wakes up at _____am
Hours of sleep _____Does your child exercise/play regularly? _____
Does your child help with household activities, such as setting the table, helping cook, clean? _____
_____

Signature: _____