

Fruit of the Womb, LLC
Biodynamic Craniosacral Therapy
Baby Intake Form

All information will be kept confidentially in your personal client file

Today's Date _____
Parents' Names and gender pronouns _____
Email _____ Phone number _____
Address _____

Emergency contact name and number _____

Baby's name _____ sex/gender/pronouns _____
Date of Birth _____ Age today _____

What are your hopes and intentions in seeking Biodynamic Craniosacral Therapy for your baby?

Please share baby's current symptoms, your concerns, and any health conditions, medical history, other treatments, supplements, or medications baby is taking.

Please share briefly about this baby's conception, pregnancy, birth, and postpartum period. We will talk more extensively in person. This space can be used for notes to help us remember what to talk about. Feel free to write a lot, if it's helpful to you!

How/what is baby eating/drinking? E.g. Breastfeeding, pumped breastmilk, formula, solids, etc. And how are things going with feeding, digestion, and elimination?

Please tell me about baby's sleep patterns, including any concerns around sleeping and waking patterns_____

What have you noticed about baby's movements, symmetry, tension, and developmental milestones?

Please describe anything about your own physical, emotional, mental, and/or spiritual well-being you would like to share.

Please share anything else you would like me to know about you, your baby, your family, or your parenting journey.

Any questions you have about this work or about me?_____
