

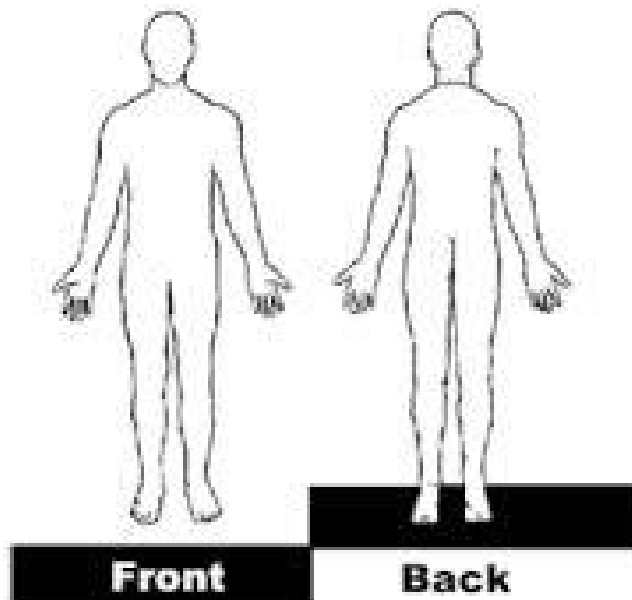
**Fruit of the Womb, LLC**  
**BCST Parental Assessment for Baby**

Name \_\_\_\_\_ Date \_\_\_\_\_

**Please mark on the images below any areas where you are noticing your baby experiencing restriction, congestion, blockage or discomfort:**

**For the following questions “1” indicates worst, “10” indicates best. All the questions are about your baby except the last:**

<b>Level of pain, stress or discomfort?</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>	<b>10</b>
<b>Quality &amp; patterns of sleep?</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>	<b>10</b>
<b>Ease/challenges with feeding?</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>	<b>10</b>
<b>Digestion and elimination?</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>	<b>10</b>
<b>Developmental milestones?</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>	<b>10</b>
<b>Your level of stress?</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>	<b>10</b>





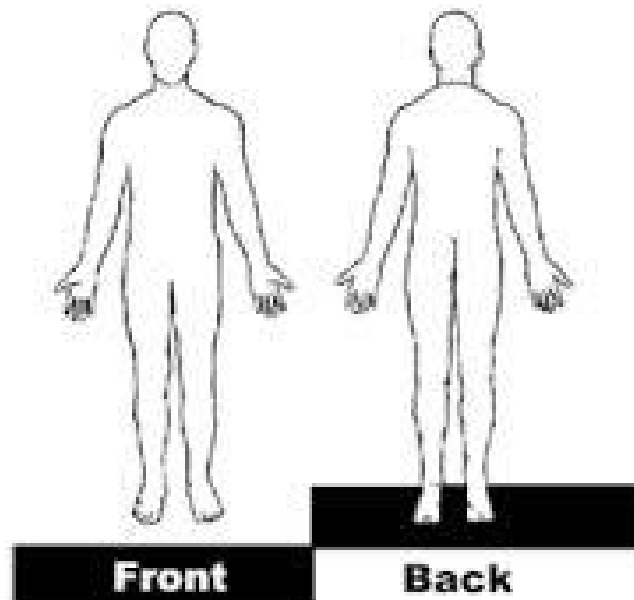
## Parental Baby Reassessment

Name \_\_\_\_\_ Date \_\_\_\_\_

Please mark on the images below any areas where you are noticing your baby experiencing restriction, congestion, blockage or discomfort:

For the following questions “1” indicates worst, “10” indicates best. All the questions are about your baby except the last:

Level of pain, stress or discomfort?	1	2	3	4	5	6	7	8	9	10
Quality & patterns of sleep?	1	2	3	4	5	6	7	8	9	10
Ease/challenges with feeding?	1	2	3	4	5	6	7	8	9	10
Digestion and elimination?	1	2	3	4	5	6	7	8	9	10
Developmental milestones?	1	2	3	4	5	6	7	8	9	10
Your level of stress?	1	2	3	4	5	6	7	8	9	10



Use back of paper too

What is your impression of your baby's condition now, relative to when your baby began receiving BCST?

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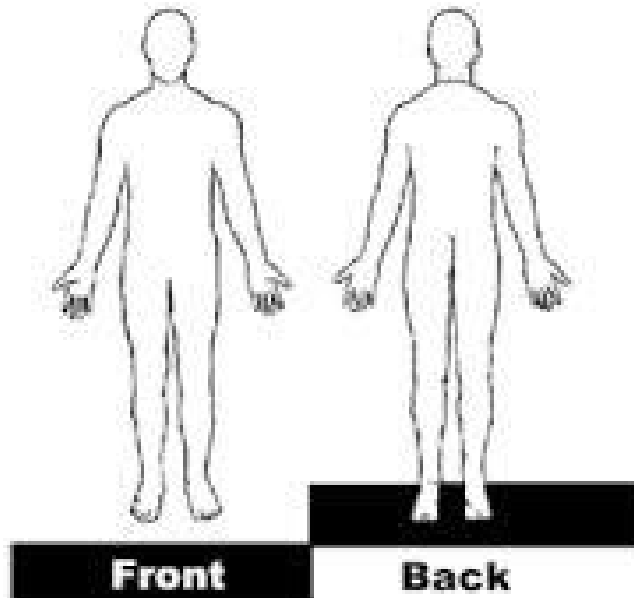
## Parental Baby Reassessment:

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Level of pain, stress or discomfort?	1	2	3	4	5	6	7	8	9	10
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Ease/challenges with feeding?	1	2	3	4	5	6	7	8	9	10
Digestion and elimination?	1	2	3	4	5	6	7	8	9	10
Developmental milestones?	1	2	3	4	5	6	7	8	9	10
Your level of stress?	1	2	3	4	5	6	7	8	9	10



Use back of paper too:

What is your impression of your baby's condition now, relative to when your baby began receiving BCST?

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