

# Infant Report Form

Date: \_\_\_\_\_ Infant's name: \_\_\_\_\_

Mother's Surname: \_\_\_\_\_ Mother's first name: \_\_\_\_\_

Please, list the name of the physician who referred you to The Body Group: \_\_\_\_\_

Physician's Diagnosis: \_\_\_\_\_

In addition to the infant, how many children do you have? \_\_\_\_\_

Please, state the age of each child: \_\_\_\_\_

Infant's blood type: A  B  AB  O  RH+  RH-

Is the infant currently taking medication? Yes  No

If yes, how long has the infant been taking medication? \_\_\_\_\_

## Birth Information

Type of birth delivery: Natural  Caesarian  Emergency Caesarian

If delivery was by emergency caesarian, please indicate reason:

\_\_\_\_\_  
\_\_\_\_\_

Did you make use of antibiotics following the delivery? Yes  No

Was assistance by means of forceps or ventouse used for the delivery? Yes  No

Was the umbilical cord around the infant's neck? Yes  No

## Feeding Information

Is the infant fed breast milk? Yes  No

Is the infant fed formula? If yes, list brand name: \_\_\_\_\_ Yes  No

Does the infant have frequent hiccups? Yes  No

Does the infant stay latched-on for the entire feed? Yes  No

Is the infant fussy when feeding? Yes  No

Does the infant spit up? Yes  No  If yes, after every feed? Yes  No

Is the spitting-up projectile vomiting? Yes  No

What is the approximate volume (e.g. 1 tablespoon, ½ cup) the infant generally spits up? \_\_\_\_\_

Please, indicate the frequency at which the infant is fed: \_\_\_\_\_

Please, indicate the duration of the feedings: \_\_\_\_\_

Does the baby wind easily/often? Yes  No

Are bowel movements regular? Yes  No

Are bowel movements explosive? Yes  No

- Please, continue on the reverse side -

# Infant Report Form

---

## Sleeping Pattern

---

Does the infant sleep well? Yes  No

> If no, is it because the infant is unsettled? Yes  No

How many times does the infant wake during the night?

1  2  3  4  More than 5

What is the infant's sleeping position? \_\_\_\_\_

Other information on sleep behavior:

---

---

---

---

## Observations

---

Does your child only look in one direction? Yes  No

> If yes, when did you first observe the behavior? \_\_\_\_\_

Does the infant generally move both arms and legs equally? Yes  No

Additional comments and observations:

---

---

---

---

---

---

---

---

Therapist's notes:

---

---

---

---

---

---

---

---