

**Intake form babies / children up to 0-2 years**

Please fill in the questions below as clearly and accurately as possible. The answers will be discussed during the intake interview.

**Personal data:**

Name: First Name: Man / Woman:

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| --- |
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|  |
| --- |
|  |

Address:

|  |
| --- |
|  |

Postal Code: City:

|  |
| --- |
|  |

|  |
| --- |
|  |

Date Of Birth: Place Of Birth:

|  |
| --- |
|  |

|  |
| --- |
|  |

Phone Number: Cell Phone Number:

|  |
| --- |
|  |

|  |
| --- |
|  |

Email Address: Family Situation:

|  |
| --- |
|  |

|  |
| --- |
|  |

GP Practice: City/Place:

|  |
| --- |
|  |

|  |
| --- |
|  |

|  |  |
| --- | --- |
|  | Yes, I give permission to inform my doctor if needed. |

Medicines/Reason:

|  |
| --- |
|  |

Specialist current/former:

|  |
| --- |
|  |

Location/Hospital: City/Place:

|  |
| --- |
|  |

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| --- |
|  |

How have you been informed about us?

|  |
| --- |
|  |

**Complaints**

What is the complaint?

|  |
| --- |
|  |

Did you have a difficult pregnancy?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

Have you been in an accident during your pregnancy?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

Has the birth been difficult / long / shortly before the calculated time?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Difficult |  | Long |  | Short |

Has the birth been induced? Accelerated / slowed down

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

Have you been pushed on your abdomen during birth?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

Have you been asked to stop pushing out the baby, by walking and pressing your legs together?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

Has the child cried properly after birth?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

Was it a birth with mento-posterior position (face presentation)?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

Was it a birth with breech presentation?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

Has there been use of vacuum extraction / spatula / forceps delivery?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

Was the birth through a caesarean section? Planned / urgent

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

**Baby to child (8 days / 24 months)**

Are you breast-feeding your child?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

When your child is breastfed, does it have difficulties with suction?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

Does your child always spit up after drinking?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

Does your child vomit often or always after drinking?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

Does your child have excessive saliva? (more than one bib between two lactations)

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

Does your child regularly have the hiccups?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

Does your child appear hyperactive?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

Does your child seem awake for his age?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

Does your child have sleeping difficulties?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

How many hours does your child sleep approximately per day?

|  |
| --- |
|  |

Does your child always cry before falling asleep and after waking up?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

Is the head flattened on one side / back / top

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

Are there any problems with the stool?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

Smelly?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

Is there diarrhea?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

How often?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

Does your child have watery eyes (one or both)?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

If you move your baby on the changing table, does the back feel stiff?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

Does your baby's belly feel hard?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

If your child is lying on your arm or is getting a clean diaper, are there any signs of pain?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

Does your child sometimes contract convulsively?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

Does your child stretches out when it stiffens itself?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

Does your child sometimes throw its head back?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

Does your child need its head in contact with the wall while lying in the cradle?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

Does your child always sleep on the same side?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

Does the head always turn to the same side?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

Which side?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Left |  | Right |

**The small child 24 - 30 months to 5 years (please also fill in for the baby)**

Does your child have regular ear infections?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

Does your child have hearing impairment?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

Does your child have ear tubes?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

Does your child always breathe through their mouth?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

Does your child often have a cold?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

Has your child ever fallen down (as a baby or child)?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

Does your child often fall forwards / backwards / sideways?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

Has your child ever experienced a car accident?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

Does your child have a scoliosis despite the fact that it can barely walk?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

**What is the past history of your child: (braces; fall; fracture; accident; diseases; etc in order of age)**

|  |
| --- |
|  |

Thank you for your time and effort!

Team Osteopathy Verstraten

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