



Spine Align

Osteopathy & Wellness

BABY OSTEOPATHY

HEALTH QUESTIONNAIRE & INTAKE FORM

Please complete this form before your baby's appointment. Your answers will help us understand your baby's health history, current concerns, and individual needs.

1. BABY'S INFORMATION

Baby's full name: _____

Date of birth (DD/MM/YYYY): _____ Age: _____ Sex (optional): _____

Parent/Guardian's name: _____

Relationship to baby: _____ Phone number: _____

Email address: _____

Family doctor / Pediatrician: _____

2. REASON FOR VISIT

What is the main reason for bringing your baby to osteopathy? (Check all that apply)

- ☐ General wellness consultation ☐ Feeding difficulties ☐ Difficulty latching ☐ Reflux / frequent spitting up
- ☐ Colic / excessive crying ☐ Difficulty settling or sleeping ☐ Head preference / restricted neck movement
- ☐ Flat spot / head-shape concern ☐ Digestive or bowel concerns ☐ Postural or movement concerns
- ☐ Other: _____

When did you first notice these concerns? _____

How often does the problem occur? ☐ Occasionally ☐ Daily ☐ Frequently

Have you consulted another healthcare professional? ☐ Yes ☐ No If yes, details: _____

3. PREGNANCY & BIRTH HISTORY

Was the pregnancy full-term? ☐ Yes ☐ No If no, gestational age at birth: _____

Were there complications during pregnancy? ☐ No ☐ Yes — please explain: _____

Type of delivery: ☐ Vaginal birth ☐ Assisted vaginal birth (forceps/vacuum) ☐ Caesarean section

Any complications during labour or delivery? ☐ No ☐ Yes — please explain: _____

Did your baby require assistance after birth? ☐ No ☐ Oxygen/breathing support ☐ NICU/special care

☐ Other: _____

Birth weight: _____ Apgar scores (if known): _____

Were any concerns identified by your healthcare team at birth? _____

4. MEDICAL HISTORY

Has your baby been diagnosed with any medical conditions? ☐ No ☐ Yes: _____

Hospitalized or undergone surgery? ☐ No ☐ Yes — details: _____

Current medications or supplements? ☐ No ☐ Yes — list: _____

Known allergies or sensitivities? ☐ No ☐ Yes — specify: _____

Recent illness, infection, or injury? ☐ No ☐ Yes — explain: _____

Recent medical examination? ☐ Yes ☐ No Date/findings, if known: _____

5. FEEDING & DIGESTION

How is your baby fed? ☐ Breastfeeding ☐ Bottle-feeding breast milk ☐ Formula ☐ Combination

☐ Solids (if age-appropriate)

Feeding concerns (check all that apply): ☐ None ☐ Difficulty latching ☐ Difficulty sucking/swallowing

☐ Clicking sounds ☐ Coughing/choking during feeds ☐ Feeds take a long time ☐ Other: _____

Digestive concerns: ☐ None ☐ Frequent spitting up ☐ Vomiting ☐ Excessive gas ☐ Constipation

☐ Diarrhea ☐ Discomfort after feeding

Is your baby gaining weight as expected, according to their healthcare provider? ☐ Yes ☐ No ☐ Unsure

Additional feeding or digestive concerns: _____

6. SLEEP & COMFORT

Does your baby have difficulty settling or staying asleep? ☐ Yes ☐ No

Does your baby seem uncomfortable when lying on their back? ☐ Yes ☐ No

Does your baby consistently turn their head to one side? ☐ Yes ☐ No ☐ Unsure

Does your baby cry excessively or appear difficult to soothe? ☐ Yes ☐ No

Describe your baby's usual sleep pattern and any concerns: _____

Safe-sleep reminder: place baby on their back for every sleep, on a firm, flat sleep surface.

7. MOVEMENT & DEVELOPMENT

Preference for turning the head to one side? ☐ Yes ☐ No

Difficulty turning the head in either direction? ☐ Yes ☐ No ☐ Unsure

Flat spot or asymmetry in head shape? ☐ Yes ☐ No ☐ Unsure

Does your baby move both arms and legs similarly? ☐ Yes ☐ No ☐ Unsure

Any concerns about development or movement? ☐ No ☐ Yes — explain: _____

8. CURRENT HEALTH & SAFETY SCREENING

Please indicate whether your baby currently has or recently experienced any of the following:

☐ Fever / suspected infection ☐ Difficulty breathing ☐ Poor or significantly reduced feeding

☐ Fewer wet diapers than usual ☐ Repeated or forceful vomiting ☐ Blood in vomit or stool

☐ Unusual drowsiness / difficulty waking ☐ Seizures / unresponsiveness ☐ Recent fall, injury, or trauma

☐ None of the above

Details of any concerns: _____

Important: If your baby has difficulty breathing, is difficult to wake, has a seizure, or appears seriously unwell, seek emergency medical care. A baby under 3 months with a temperature of 38°C (100.4°F) or higher needs urgent medical assessment. Osteopathic treatment should not delay medical evaluation.

9. PARENT / GUARDIAN'S GOALS

What would you most like help with during your baby's visit? _____

What changes would you hope to see following the appointment? _____

Anything else you would like the osteopath to know? _____

10. CONSENT & ACKNOWLEDGEMENT

I confirm that the information provided is accurate and complete to the best of my knowledge. I understand that this information helps the osteopath determine whether an assessment is appropriate and whether referral to another healthcare professional may be necessary.

I understand that assessment and treatment will be explained before proceeding; I may ask questions or withdraw consent at any time; I may comfort, feed, or hold my baby during the appointment; and osteopathic care is not a substitute for appropriate medical care, pediatric assessment, or emergency services.

Parent/Guardian's full name: _____

Signature: _____ Date: _____

Osteopath's name: _____

FOR CLINIC USE ONLY

Date of assessment: _____

■ Medical history reviewed ■ Safety screening reviewed ■ Parent/guardian concerns discussed

■ Assessment findings documented ■ Referral / further medical assessment indicated ■ Consent obtained

Clinical notes: _____

Osteopath's signature: _____