Jane Reynolds

CRANIAL OSTEOPATHY FOR BABIES AND KIDS

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Registered Osteopath with the General Osteopathic Council since 2004

*For clinic use only: Date:*

*DIAGNOSIS:*

*Short-term objective*

*Long-term objective*

*Number of treatments required*

*Length of treatment*

*Prognosis*

*Maintenance?*

*Other*

Confidential Patient Health Questionnaire

Personal details (Baby)

Surname: First Name:

Mother/Father’s name:

Address:

Best Phones: Email:

D.O.B.: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor’s details (GP)

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the reason for seeking my help today and what do you hope to gain from treatment?

Tell me about your pregnancy and your general health and well-being (mum)

Tell me about the birth.

What was baby’s birth weight?

Were there any complications or interventions e.g.. ventouse, caesarian section, forceps?

How long after birth did baby latch on?

What is baby being fed?

Any problems feeding?

How is baby’s weight?

How is baby’s sleep?

Where does baby sleep?

What colour is baby’s poo?

Is baby sicky?

Is baby windy? Which end if yes?

Has baby received any medication?

Are you taking any medication or did you during the pregnancy?

Do you have any food sensitivities?

Has baby had any falls or knocks?

Does baby yawn a lot?

Does baby hiccup a lot?

How did you hear about me?

Is there anything else you would like me to know?

(Please see overleaf)

Informed Consent

Your “Informed Consent” is required for all treatment provided. You may withdraw your consent at any time. Treatment will cease if consent is withdrawn. If you become uncomfortable with your treatment at any time please let me know.

Fees and cancellation policy

Appointments cancelled less than 24 hours beforehand may be charged at 50% depending on the circumstances. Please call the clinic to discuss. Missed appointments will be charged at 100% unless in the case of an emergency. Again, please call the clinic to discuss. Concessions available – please ask.

The fees are as follows:

Initial consultation and treatment - 45 minutes £60

Follow-up treatments – up to 45 minutes £50

TERMS AND CONDITIONS OF TREATMENT

I have read the Conditions of Treatment and Informed Consent information.

PLEASE SIGN BELOW (CLINIC COPY)

I give consent for treatment of my child. I agree to this consent remaining valid until further notice.

Parent’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The cancellation policy has been made known to me (please read clearly above) and I agree to pay a cancellation fee if required.

Parent’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_