Welcome to Body & Brain Centre!

Date: ______________

Patient Name: ________________________________ **DOB:** ______________ **Age:** _______

Parent 1's Name: ______________________ **Parent 2's Name:** ________________________

Siblings' Names & Ages: ____ ❐ Same home

Address: _______________________________ **Suburb:** ____________ **Postcode:** _______

Parent 1 Mobile: _____________ **Parent 2 Mobile:** _____________ Please call ❐ #1 ❐ #2 first

Email Address: ____
Please Tick: ❐ I would like to receive newsletters with special offers, health tips and more.

Who can we thank for referring you? ________________ PS they will get a thank-you voucher

If online, what search words were used? ____

Pregnancy

Where there any difficulties during pregnancy? This may include stress, illness or fears about health of baby or you. ____
____

Supplements / Medication Taken: _________________________________ ❐ Prenatal Vitamin

Birth

How long was the labour? From first contraction until birth ___________ **Push time?** _______

How Many Weeks? ___________ **Birth Weight:** ___________

How was your Child Delivered? ❐ Vaginal ❐ Caesarian (planned) ❐ Caesarean (emergency)

How did your Child Present? ❐ Crown / Top of Head First ❐ Face First ❐ Breach ❐ Other (detail)

Were any Interventions Used? ❐ Epidural ❐ Induction ❐ Forceps ❐ Suction ❐ Other (detail)

Did your child experience: ❐ Intensive care unit (NICU) ❐ Resuscitation ❐ Misshapen head

Details: ____

Do you believe the birth process was traumatic for your child? ______________________
____

Infant History

Is/was your child breastfeed? ❐ No ❐ Yes currently ❐ Yes previously **For how long?** ________

Is your child currently on formula? ❐ Yes ❐ No **If so, what one?**______________________

Age when solids were introduced? _________ **Any dietary requirements?** _____________

Number of solid meals a day? ________ **How many milk feeds a day?** _______________

What does a typical meal look like? ____

Can your child

❐ Sit up unassisted ❐ Crawl ❐ Pull to stand ❐ Walk holding furniture ❐ Walk unassisted

Overall Health

Has Your Child Had or Having Problems with:

Past	Current	N/A		Past	Current	N/A	
❒	❒	❒	Bowels	❒	❒	❒	Eczema / Skin Conditions
❒	❒	❒	Breastfeeding Difficulties	❒	❒	❒	Allergies / Intolerances
❒	❒	❒	Convulsions, seizures	❒	❒	❒	Poor sleep (provide details)
❒	❒	❒	Recurrent Bladder Infections	❒	❒	❒	Sensitivity to Light, Touch, Noises
❒	❒	❒	Recurrent Throat Infections	❒	❒	❒	Colic
❒	❒	❒	Recurrent Ear Infections	❒	❒	❒	Moodiness
❒	❒	❒	Reflux / GERD	❒	❒	❒	Sinus
❒	❒	❒	Co-Ordination / Movement	❒	❒	❒	Flat Head (Plagiocephaly)
❒	❒	❒	Epilepsy / Seizures	❒	❒	❒	Torticollis / Twisted Neck

Has Your Child Been Diagnosed with any Condition, Disorder or Disability Not Previously Mentioned? ______________________________

Please List Your Child's Medications (including Supplements) - current & previous:

____

Has your child recently been vaccinated? ❒ Yes ❒ No

Have there been any major changes recently? ❒ Yes ❒ No
Details: ______________________________

Please describe your child's temperament? ❒ Easy ❒ Slow to warm up ❒ Difficult ❒ Mixed

Sleep History

What are your main concerns with sleep? ______________________________

____

How long has this been going on for? ❒ Recent (time frame: ____________) ❒ Ongoing

Let's compare where your child is currently at to where you think they should be.

	Reality	Expectation	Any comments?
Number of naps			
Duration of naps			
Nighttime sleep (hrs)			
Wakes overnight			

Where do sleeps occur? ______________________________
Does child have own room? ❒ Yes ❒ No - shared with siblings ❒ No - shared with parents

Please describe the bedroom environment? Include information like the temperature, sounds, lights & what colour they are, toys, etc. Feel free to send through photos as well.

____

____

How do you settle your baby to sleep:
Initially?____
Upon waking overnight? ____
Do you help your baby go back to sleep? ❒ Yes - every time ❒ Yes - sometimes ❒ No - never

Is your baby's bedtime routine consistent? ❒ Yes ❒ No

Are any sleep associations used? ❒ Dummy ❒ Toy ❒ Sleep suit / PJs ❒ Darkness
❒ Background noise (eg: white noise or waves)
Are these used for all sleeps? ❒ Nighttime only ❒ Day & night ❒ Daycare only ❒ Only at home

What is your daily routine?

Time	Activity (wake up, sleep, solids, milk, wind down routine, etc)

Does your child have jerky movements or restless body during sleep? ❒ Yes ❒ No

When asleep does your child rock their boy or bang head repetitively? ❒ Yes ❒ No

Does your child snore, breath with mouth open or sweat during sleep? ❒ Yes ❒ No

Does your child wake with nightmares? ❒ Yes ❒ No **Night terrors?** ❒ Yes ❒ No

Does your child get out of bed at night? ❒ No ❒ Yes
If yes, please provide details on how frequently, what he does and how you respond

____

Have you started night toilet training? ❒ Yes ❒ No **Does your child sleep walk?** ❒ Yes ❒ No

Parents

How prepared are you for change? ______________________________

Are both parents on the same page? ______________________________

What hurdles do you think may arise? ______________________________

How long do you think the sleep coaching process may take? ______________________

	Parent 1	Parent 2
Is stress a major problem?	❒ Yes ❒ No	❒ Yes ❒ No
Do you feel depressed?	❒ Yes ❒ No	❒ Yes ❒ No
Do you panic when stressed?	❒ Yes ❒ No	❒ Yes ❒ No
Do you have problems with eating or your appetitie?	❒ Yes ❒ No	❒ Yes ❒ No
Do you cry frequently?	❒ Yes ❒ No	❒ Yes ❒ No
Have you ever seriously thought about hurting yourself?	❒ Yes ❒ No	❒ Yes ❒ No
Apart from your child's disruptions, do you have sleep troubles?	❒ Yes ❒ No	❒ Yes ❒ No
Have you been to a counsellor recently or considered it?	❒ Yes ❒ No	❒ Yes ❒ No
Do you feel supported by your partner / family / friends?	❒ Yes ❒ No	❒ Yes ❒ No
If breastfeeding, are you on any medication?	❒ Yes ❒ No ❒ N/A	❒ Yes ❒ No ❒ N/A

Informed Consent For Sleep Coaching

The sleep coaching process can be as quick or as slow as your family is ready for. Techniques that are used for quicker responses may result in some frustration and grumpiness from your child. Whatever techniques and methods that are implemented are always done in a gentle and loving manner.

You are in control so if you change your mind in the middle of the night, that's ok. If you "slip up", that's ok too.

Please tick

☐ The information provided is accurate and fully inclusive to the best of my knowledge. I understand the advice and treatment plan is made on the information that I provide. I will update my practitioner on any medical conditions or health concerns as they arise.

☐ I understand I must provide 24 hours notice if I'm unable to attend my scheduled appointment to avoid paying a 50% cancelation fee. If I fail to provide notice that I cannot attend my appointment, I will be liable for 100% of the consultation fees. I also understand that all fees are payable on the day of consultation.

PARENT'S SIGNATURE______________________________ DATE____________________

SLEEP COACH'S SIGNATURE__________________________ DATE__________________