**Baby Reflexology Course/ Consultation Form**

Parent name……………………………………………………….. Contact number……………………………………..

Address…………………………………………………………………………………………………………………………………………….

GP Name/ surgery……………………………………………………….. Phone number…………………………………………

Babies name…………………….. Date of Birth………………….. Number of weeks gestation at birth…….

Place of Birth: Hospital… Birth Centre… Home… Other (please specify)…………………………………………..

Length of labour (if applicable)…………hours Spontaneous… Induced…

Type of birth: Unassisted… Vonteuse… Forceps… Induction… Caesarean… Unplanned Caesarean…

Birth problems: Shoulder Dystocia… Umbilical restriction… Isolation after birth… Meconium…

Birth process (please give details)………………………………………………………………………………….............

……………………………………………………………………………………………………………………………………………………

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Babies medical history (please give as much detail as possible, using a separate sheet of paper if needed)

During pregnancy:……………………………………………………………………………………………………………………….

At Birth:……………………………………………………………………………………………………………………………………….

Currently:…………………………………………………………………………………………………………………………………….

Illnesses/accidents etc…………………………………………….....................................................................

Current medication………………………………………………………………………………………………………………………

Developmental concerns……………………………………………………………………………………………………………..

Please give reasons for choosing reflexology including what you expect to get from this course/ treatment ……………………………………………………………………………………………………………………………………

I, …………………………………………(parent/ guardian) give consent for Caroline Svitana to treat my child

………………………………… (Child’s name) with reflexology. I acknowledge that this treatment is not a replacement for any orthodox or prescribed medical treatment. The therapy has been described to me and I am aware of any reactions that may occur.

Signed………………….………………………. Print………………..…………………………….. Date…………………………