Starting Moves℠

Pregnancy, Birth, and Health Information

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Kinetic Konnections®

Child Name: _____ **DOB:** _____ **Term Age at Birth:** _____

Parent Name(s): _____

Referred by: _____

Area(s) of Concern?

_____ Sleeping	_____ Fussing/Colicky	_____ Motor Development
_____ Feeding	_____ Self-Calming	Other: _____
_____ Gas/Pooping	_____ Social/Speech	_____

Conception History

_____ Assisted (IVF, IUI, etc.)	_____ Donor Egg	_____ Twin/Multiple
_____ Adopted	_____ Donor Sperm	_____ Surrogate
_____ Natural	_____ Other	

Pregnancy History (check all that apply)

Trimester	1	2	3		Trimester	1	2	3
Extreme Stress					Vaccines/Flu shot			
Extreme Nausea					Placenta Issues			
Illness- Mom					Pre-eclampsia			
Accident					Ultrasounds- How Many?			
Fibroids					Bed Rest/Restrictions			

Other _____

_____

_____

Birth History

_____ Induced	_____ Sunnyside Up	_____ Breathing Issues
_____ Forceps	_____ Breech	_____ Torticollis
_____ Vacuum	_____ Umbilical Cord Wrapped	_____ Club Foot
_____ C-section (Reason?)	_____ Umbilical Cord Issue	_____ Twin A
_____ Preterm Birth (Weeks _____)	_____ Missing Umbilical Vein	_____ Twin B
_____ NICU (# of Days _____)	_____ Meconium	

Other: _____

_____

_____

Early Health History and Concerns

_____ Respiratory	_____ Circulatory/Cardio	_____ Vision
_____ Digestive	_____ Head Shape	_____ Hearing
_____ Ortho/Structural	_____ Jaundice	_____ Oral
_____ Ear Infection(s)	_____ Digestive Reflux	_____ Genetic Condition
_____ Antibiotics	_____ Kidney Reflux	_____ Suck/Swallow

Others including surgery, hospitalization, home monitoring, casts, braces, etc.

_____

_____

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