

Infant's Name _____ Birth Date _____ Today's Date _____

____ Male ____ Female Birth Weight _____ Present Weight _____ Birth Location _____

____ Vaginal birth ____ C-Section Birth Any birth complications? _____

Are you breastfeeding or pumping? ____ Yes ____ No If no, how long since you stopped breastfeeding? _____

1. Infants are usually given vitamin K at birth. Did your child receive the vitamin K shot? ____ Yes ____ No

2. Was your infant premature? ____ Yes ____ No If Yes, how many weeks? _____

3. Does your infant have any heart disease ____ Yes ____ No or known bleeding diseases? ____ Yes ____ No

4. Any other medical conditions? _____

4. Has your infant had any surgery? ____ Yes ____ No What type? _____

5. Has your infant experienced any of the following? Please check / circle / elaborate as needed.

- | | |
|---|--|
| <input type="checkbox"/> Shallow latch at breast or bottle | <input type="checkbox"/> Lip curls under when nursing or taking a bottle |
| <input type="checkbox"/> Falls asleep in the middle of a feed | <input type="checkbox"/> Clicking or smacking noises when eating |
| <input type="checkbox"/> Slides or pops on and off the nipple | <input type="checkbox"/> Sucking blisters or callouses on lips |
| <input type="checkbox"/> Gagging, choking, or coughing when eating | <input type="checkbox"/> Colic symptoms / Baby cries a lot |
| <input type="checkbox"/> Poor or slow weight gain | <input type="checkbox"/> Reflux symptoms |
| <input type="checkbox"/> Hiccups often | <input type="checkbox"/> Spits up often? Amount / Frequency _____ |
| <input type="checkbox"/> Lots of <i>in utero</i> hiccups | <input type="checkbox"/> Gassy (toots a lot) / Fussy often |
| <input type="checkbox"/> Gumming or chewing the nipple | <input type="checkbox"/> Milk leaks out of the mouth when nursing/bottle |
| <input type="checkbox"/> Pacifier falls out easily or won't stay in | <input type="checkbox"/> Nose sounds congested often |
| <input type="checkbox"/> Snoring, noisy breathing, or mouth breathing | <input type="checkbox"/> Baby is frustrated at the breast or bottle |
| <input type="checkbox"/> Short sleeping and waking often | <input type="checkbox"/> Constipation or irregular stools |
| <input type="checkbox"/> Baby moves a lot in sleep/restless sleep | How long does baby take to eat? _____ |
| <input type="checkbox"/> Baby seems always hungry and not full | How often does baby eat? _____ |
| <input type="checkbox"/> Delayed crawling or walking | Anything else? _____ |

6. Is your infant taking any medications? ____ Reflux ____ Thrush Name of medication: _____

7. Any prior surgery to correct the tongue- or lip-tie? (when/where) _____

8. How are you doing mentally/emotionally? _____

9. Do you have any of the following signs or symptoms now or in the past? Please check/circle/elaborate.

- | | |
|--|--|
| <input type="checkbox"/> Creased, flattened, or blanched nipples | <input type="checkbox"/> Poor or incomplete breast drainage |
| <input type="checkbox"/> Lipstick-shaped nipples | <input type="checkbox"/> Decreasing milk supply |
| <input type="checkbox"/> Blistered or cut nipples | <input type="checkbox"/> Plugged ducts / engorgement / mastitis |
| Pain on a scale of 0-10 when first latching _____ | <input type="checkbox"/> Nipple thrush |
| Pain (0-10) during nursing _____ | <input type="checkbox"/> Using a nipple shield |
| <input type="checkbox"/> Feelings of hopelessness/depression | <input type="checkbox"/> Baby prefers one side over other ____ (R/L) |

Primary Care Provider _____ Chiropractor/PT/CST _____

Lactation Consultant _____ Other Therapist/Provider _____

Who referred you to us? _____

Doctor's Signature _____

