Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient’s DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient’s age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex:\_\_\_

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent’s Name(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City, State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_

Insurance Subscriber DOB: \_\_\_\_\_\_\_\_\_\_\_Insurance Subscriber ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Subscriber SSN: \_\_\_\_\_\_\_\_\_\_\_\_

Pediatrician’s Name and Office: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently working with a lactation consultant? Yes No

If yes, who and when did you last see them? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your child currently being seen for other services? (chiropractic care, physical therapy, occupational therapy, craniosacral therapy, speech therapy, feeding therapy, osteopathy, etc.) Yes No

If yes, what type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Provider(s) Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, when/total number of visits? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any concerns with your child’s gross motor development? (rolling, sitting, crawling, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have a preference for turning or tilting his/her head? (in car seat, stroller, while sleeping, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this your first child? Yes No Family history of tongue ties? Yes No

Has Dr. Annie treated you or a family member in the past? Yes No If so, who/when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please summarize your main concerns/reason for visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY**

Birth weight (lb/oz): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Most current weight (lb/oz): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all current **maternal** medications/supplements: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all current **child** medications/supplements: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have any allergies? (Food, medication, etc.) Yes No If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did your child receive Vitamin K injections? Yes No

Are your child’s vaccines up to date? Yes No

Does your child have any heart disease? Yes No If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child had any surgeries? Yes No If yes, what type(s) and when?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child had prior surgery to correct a tongue or lip tie? Yes No

If yes, what type(s) and where?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have any other medical conditions or health concerns? Yes No

If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PREGNANCY/LABOR HISTORY**

Birth location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was the pregnancy high risk? Yes No

Was your child premature? Yes No If yes, gestational age at birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were there any additional stressors with labor? Yes No

Please circle all that apply: Vaginal birth Long labor Unplanned C-section Planned C-section Excessive pushing

Trauma from vacuum or forceps Breech birth Other (please explain): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Difficulty with latch after birth? Yes No

**MODE OF FEEDING**

Please describe your current mode(s) of feeding: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently breastfeeding? Yes No

If yes, please select: Exclusively breastfeeding Mix of breast/bottle feeding

How would you rate your milk supply? Oversupply Good Fair Poor

Do you have a history of breast surgery? Yes No

Are you currently using a nipple shield? Yes No

Are you using a supplemental nursing system? Yes No

Is this your first time breastfeeding? Yes No N/A If no, how long did you breastfeed other children? \_\_\_\_\_\_\_\_\_\_

Are you currently bottle feeding? Yes No If yes, what type of bottles?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you supplementing with pumped breast milk? Yes No How many bottles/ounces per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you supplementing with formula? Yes No How many bottles/ounces per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of formula: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your baby use a pacifier? Yes No

**BABY’S SYMPTOMS**

Does your baby CONSISTENTLY fall asleep while attempting to nurse/feed? Yes No

Does your baby CONSISTENTLY slide off the breast while latching/feeding? (Skip if N/A) Yes No

Does his/her upper lip CONSISTENTLY curl inward (does not flip out when latched?) Yes No

Does your baby CONSISTENTLY have his/her mouth open at rest? Yes No

Does milk or formula leak/spill out of mouth while feeding at breast/bottle? Yes No

Does your baby CONSISTENTLY experience colic symptoms? Yes No

Does your baby CONSISTENTLY become visibly frustrated at the breast/bottle? Yes No

Does your baby CONSISTENTLY exhibit reflux symptoms? Yes No

Is your baby CONSISTENTLY extremely gassy? Yes No

Does your baby CONSISTENTLY snore during sleep? Yes No

Does your baby CONSISTENTLY exhibit noisy/congested breathing? Yes No

Has your pediatrician noted slow or poor weight gain? Yes No

Have you done any pre- and post- feeding weight checks?

If so, what was the transfer rate?: \_\_\_\_\_ ounces per \_\_\_\_\_ minutes

Does your baby CONSISTENTLY display gumming or chewing of your nipple while nursing? Yes No

Is there a CONSISTENT “clicking noise” while feeding? Yes No

Does your baby seem CONSISTENTLY dissatisfied after feeding sessions? Yes No

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the average length of feeding time in minutes? -Less than 15 -15-30 -30-45 -45-60 -60+

**MOTHER’S SYMPTOMS (if breastfeeding)**

Please rate your level of discomfort while feeding: None Very Low Low Medium High Very High

Are your nipples becoming creased/flattened/lipstick-shaped/blanched white after nursing? Yes No

If yes, please select: Right Side Left Side Both

Are your nipples becoming cracked, bruised, or blistered after nursing? Yes No

If yes, please select: Right Side Left Side Both

**MOTHER’S SYMPTOMS CONTINUED**

Are your nipples bleeding? Yes No

If yes, please select: Right Side Left Side Both

Is there any severe pain when your baby attempts to latch? Yes No

If yes, please select: Right Side Left Side Both

If yes, please select: Pain subsides after initial latch Pain persists throughout feeding Pain is felt in-between feeds

Are you experiencing poor or incomplete breast drainage? Yes No

Do you have a history of, or currently have, mastitis? Yes No

Do you have a history of, or currently have, nipple/baby oral thrush? Yes No

**CONCERNS AND GOALS**

In a sentence or two, please share your current feeding concerns:

In a sentence or two please share your feeding goals: