Infant Consultation Intake Form

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.

____ Shallow latch at breast or bottle
____ Falls asleep in the middle of a feed
____ Slides or pops on and off the nipple
____ Gagging, choking, or coughing when eating
____ Poor or slow weight gain
____ Hiccups often
____ Lots of in utero hiccups
____ Gumming or chewing the nipple
____ Pacifier falls out easily or won't stay in
____ Snoring, noisy breathing, or mouth breathing
____ Short sleeping and waking often
____ Baby moves a lot in sleep/restless sleep
____ Baby seems always hungry and not full

____ Lip curls under when nursing or taking bottle
____ Clicking or smacking noises when eating
____ Sucking blisters or callouses on lips
____ Colic symptoms / Baby cries a lot

____ Reflux symptoms
____ Spits up often? Amount / Frequency_____
____ Gassy (toots a lot) / Fussy often
____ Milk leaks out of mouth when nursing/bottle
____ Nose sounds congested often
____ Baby is frustrated at the breast or bottle
____ Constipation or irregular stools

How long does baby take to eat? _____
How often does baby eat? _____
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.
____ Creased, flattened, or blanched nipples
____ Lipstick shaped nipples
____ Blistered or cut nipples
Pain on a scale of 0-10 when first latching _____
Pain (0-10) during nursing _____
____ Feelings of hopelessness/depression
____ Poor or incomplete breast drainage
____ Decreasing milk supply
____ Plugged ducts / engorgement / mastitis
____ Nipple thrush
____ Using a nipple shield
____ Baby prefers one side over other _____ (R/L)
10. What are your breastfeeding/bottle feeding goals?
_____

Primary Care Provider _____
Chiropractor/PT/CST_____
Lactation Consultant _____ Other Therapist/Provider_____
Who referred you to us? _____
How far away do you live? _____
Doctor's Signature _____