



FOR OFFICE USE: Appt: Time and Date		
--	--	--

LACTATION IN-TAKE FORM

Patient's Name:		Date	
Allergies		DOB	
Medical History:		Sex:	Birth Weight
Did your child receive the Vitamin K shot at birth?	Yes	No	Unsure
Does either parent have a known bleeding disorder (Hemophilia, von Willebrands, etc.)?	Yes	No	

URGENCY OF APPOINTMENT?	Please choose one:	Extremely Urgent	ASAP	Within the next 2-3 weeks
--------------------------------	--------------------	------------------	------	---------------------------

PREVIOUS REVISION			
When was the previous revision completed?		Where was the previous revision completed?	

PARENT/ GUARDIAN INFORMATION			
Primary Email:			
Parent's Full Name:		Phone:	
Street Address:			
City, State:		Zip Code:	

REFERRAL SOURCE			
Lactation Consultant / Physician:		Organization:	
Phone #:			
Other:			

PLEASE EMAIL ALL PICTURES AND INTAKE FORM TO: PBAHN@infantlaserdentistry.com

If possible, please attach photos of your child's upper lip, with it reflected up toward the nose to see the upper lip frenulum and the area under the tongue, with the tongue reflected up towards the roof of the mouth.

Patient Name:				Birth Order: 1 2 3 4+								
Child Born at	Weeks	Vaginal	C-Section	Assisted (Vacuum / Forcep)		Hours in Labor	Time Spent Pushing					
Did any issues arise in the process of getting pregnant or during the pregnancy? If so, please circle the appropriate answer or add any other issues that may be of interest in regard to the mother.						IVF	IUI	PCOS				
						IGT		Thyroid Issues				
						Hx of Breast Surgery			HELLP Syndrome			
						Raynaud's Phenom.			Excessive Blood Loss			
Does the mother or father of the child have any keloids, or dense, thicker scars they form when the skin heals?						Yes	No	Unknown				
How long would you like to nurse your child?						Months						
In the past week or two, how many times per day is the child either breastfeed exclusively, breastfed/pumping/bottle feeding, strictly bottle fed, some combination of these?						Nursing x day,						
						Nurse, Pump, Bottle Feed x day						
						Bottle Feeding x day						
The answers outlined below should be focused on the last few days or weeks of nursing, depending on the age of to the infant. These answers will be helpful in completing a more comprehensive assessment.												
MOTHER SYMPTOMS												
1.	Does the mother use a nipple shield currently with nursing and what is the reasoning (Choose all that apply)?					NO						
						YES						
						If Yes, Why?	Anatomical Issue					
						Pain Relief	Allow Latching					
2.	How uncomfortable is nursing when the baby latches (the first 30 seconds) and then how uncomfortable is the nursing once the baby is latched and nursing?					Scale of 1-10						
						/10 Latch		/10 Overall				
3.	What type of discomfort, if any, is felt during the nursing session. You can pick as many as best describe the sensation.					Chomping	Pinching	Burning				
						Flicking	Razor Blades	Rubbing				
						Stabbing		Soreness				
4.	Do you have blanching or white nipple tips once you are done nursing or do you feel a shooting pain (vasospasm) after nursing that radiates up the chest and towards the back					NO						
						YES, Blanched Nipples						
						YES, Vasospasm						
5.	When the nursing session is complete, is the nipple distorted in shape and if so, what do they look like?					Crease	Lipstick Shaped	Flattened				
						Rounded		Elongated				
6.	Have you had any clogged/plugged ducts or episodes of mastitis with the infant?					Clogged Ducts x		Mastitis History x				
7.	In the past 2 weeks of nursing, has any cracking, bleeding, blistering or physical trauma occurred to the nipple/breast?					NO	Cracks	Bleeding				
							Blebs	Bruising				
							Blistering					
8.	When nursing, does the infant make a sustained pulling sensation (almost like the pump) when nursing or to a lesser degree? If so, does the pulling or tug sensation occur in a short burst with your letdown, or throughout most of the nursing session.					Does it feel like a vacuum?						
						YES	NO	LESSER				
						If so, how long does it last?						
						SHORT BURST		CONSTANT				
9.	How would you rate your current supply in the past 2 weeks? And do you feel or have you been told you have a strong or forceful letdown? Circle the best answer that applies, or if between two answers, circle both.					Maternal Oversupply		Normal Supply				
						Lower Supply		Strong Letdown				
10.	When the nursing session ends, does the breast(s) feel empty? If not, and you pump afterwards, how much more milk can you pump out?					YES	NO	AT TIMES				
						Pumping post nursing: ____ oz						

11.	Have you ever done a weighed transfer with your LC? You weigh the baby, nurse and then re-weigh the baby to assess the amount transferred. When was this done (at how many weeks) and how long does a normal session last? Was it from one side or both sides?	Performed at		weeks of age		
		Fed for		minutes		
		Pulled	oz.	Right	Left	BOTH
12.	Any other notes or comments: Taking herbal supplements, block feeding, any food allergies or dietary modifications, any family history of tongue tie, etc.					
CHILD'S SYMPTOMS						
1.	Has overall weight gain for the infant been slow or of concern. If of concern, what % of the birth weight did the child lose if they are under 2 months old.	NO		YES		
		Lost		% of birth weight		
2.	How long do nursing session typically last? Every how many hours does the infant nurse during the day and then at night?	Nurses for Hours (Day)		minutes every Hours (Night)		
3.	Do you hear a clicking or popping sound when the child is nursing from the breast or bottle?	NO		YES		
4.	Does the infant have a shallow latch or slides to the end of the nipple while nursing?	NO		YES		
5.	Does the infant go on and off frequently while nursing?	NO		YES		
6.	Do you have to support the infant's head <u>and</u> perform manual breast compressions to express milk to the infant?	NO		YES		
7.	Do you hear a gulping sound with nursing?	NO		YES		
8.	Does the infant fall asleep in the first few minutes of nursing or fatigue easily?	NO		YES		
	Does the jaw or chin flutter or quiver during feeding?	NO		YES		
9.	Does the infant sleep with the head extended back or are they a loud sleeper?	NO		YES		
10.	Are you able to flange the upper lip out while breastfeeding or while bottle feeding?	NO	YES, Mother		YES, Bottle	
11.	Does your child have excessive gas episodes or air intake while nursing?	NO		YES		
12.	Does the baby leak a lot of milk while nursing (breast) or from a bottle?	NO	Breast Bottle	YES	Breast Bottle	
13.	Does the baby have excessive painful spit-up episodes or exhibit reflux symptoms?	NO		YES		
14.	If reflux exists, does the infant take any medicine for it? If so, what is the medicine and for how many weeks have they been using the medicine? In your opinion, has the medicine helped with the reflux?	Medication:		for wks		
		Has it helped symptoms?				
		Yes		No		Unsure
15.	During a typical day, how much of the daily intake of milk is breastmilk or formula or some combination.	Exclusively Breastfed:				
		Supplemented with Formula:				
16.	What types of bottles do you use, if any?					
17.	Is the infant able to hold a pacifier?	YES	WITH DIFFICULTLY		NO	
	What type of pacifier do you use or have tried?	Type:				
		NUK	Soothie		Mam	
		Do Not Utilize a Pacifier				
18.	Who is your primary lactation consultant you will be following up with after the visit?					
19.	Does your child have any other comments that were not covered above? Struggles with bottles, excessive drooling, bowel color/frequency issues, torticollis or open mouth breathing?					