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 of 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, 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 minutes every Hours (Day) 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 and 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? What type of pacifier do you use or have tried?	◯ YES ◯ WITH DIFFICULTLY ◯ NO Type: ☐ NUK ☐ Soothie ☐ Mam ☐ Do Not Utilize a Pacifier
18.	Who is you 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 or open mouth breathing?	