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)

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 __________________________________