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Parent and Infant Intake for Lactation Services

Please provide as true and accurate up-to-date information as possible. This information may aid in my best ability to counsel you on your needs and/or give referrals as deemed necessary.

Parent Information ▼

Parent Name:	Parent Address:
Parent Email:	
Parent Phone: ☐ Home ☐ Cell	
Parent Insurance Provider:	Parent DOB:
Policy Number:	Group Number:

Infant(s) Information *(For Multiples Complete a Separate Intake Form for Infant Side)* ▼

Infant Name:	DOB:
Infant Insurance Provider:	Pediatrician:
Policy Number:	Group Number:

Parent Basic Health History and Lactation Overview ▼

Do *you or your infant* have any known allergies to food, medications, latex, or wool?
▶

Are you currently using any medications or galactogogues? ("Milk Boosters")
▶

Have you been diagnosed with any health concerns that may affect milk production or just that you would like to inform me of? *(Summarize Below or write "None" "Not Known")*
▶

Basic History of Breast / Chest ▼

Did your breast/chest change in size and/or fullness during puberty? ☐ Yes ☐ No

Did your breast/chest change in size sensitivity, fullness, areola size increase and/or darkening during pregnancy? ☐ Yes ☐ No

Do you have a history of breast/chest injury or augmentations such as implants, reductions, or other surgery involving your breast/chest?
▶

Pregnancy, Birth, and Postpartum ▼

Did you experience any remarkable health concerns during pregnancy or postpartum that you would like me to inform me of? *(Summarize Below or write "None")*
▶

Infant(s) Basic Health History and Feeding Overview ▼

Has your infant been diagnosed with any remarkable health concerns that may affect feeding or just that you would like to inform me of? *(Summarize Below or write "None")*
▶

Has your infant been diagnosed with any feeding, swallowing, or oral restrictions, such as cleft(s) or tongue, buccal, or lip tie(s)? *(Summarize Below or write "None")*
▶

Have you have you had the tie(s) released? ☐ Yes ☐ No

Date of tie(s) release?

Who preformed the release?

Infant Weight Information ▼

Weight at birth (lbs and oz):

Percentage of birth weight lost:

Total time to regain birth weight:

Most recent weight(s) (lbs and oz)▼

Date:	Wt.:
Date:	Wt.:

Does the health care provider have any concerns about your infant's weight? *(Summarize Below or write "None")*
▶

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Pregnancy, Birth, and Postpartum Continued ▼	Approx. how many heavy wet diapers in *24hr*?
Type of birth: ☐ Vaginal ☐ Unmedicated ☐ Induction ☐ Homebirth ☐ Ceserean ☐ Ceserean After Trial of Labor ☐ Hospital Birth ☐ VBAC ☐ VBAMC ☐ Adoption ☐ Birth Center	Approx. how many bowel movements in *24hr*? What color are the bowel movements? Where does baby sleep?

Breast/Chest Feeding, Infant Feeding, and Milk Expression Overview ▼

Skin-to-Skin (Golden Hour) or breast/chest/nipple stimulation directly after birth (within 30 min-1 hour)? ☐ Yes ☐ No

Describe your breast/chest feeding experience in the first 48 hours
(Consider sharing any obstacles you had experienced, positive/negative experiences, how obstacles were handled, and how you felt about your experiences)
►

Have you previously breast/chest feed by nursing and/or expressing milk? For how long?

Did you see a lactation professional since the birth of your infant(s)? Who and when:

Briefly describe the reason(s) for reaching out for lactation services *(ex. latching difficulty, sore nipples, lack of support, assistance with milk expression or feeding methods, infant unsettled at breast, infant weight gain concerns, milk supply concerns, etc.)*
►

Are you familiar with pace feeding? ☐ Yes ☐ No		Breast pump brand and model:	
Bottle brand are you using or plan to use?		Is your breast pump brand new or used? ☐ New ☐ Used	
Are you currently supplementing or using a human milk fortifier? ►	Method of supplementation, amount and how often? ►	*Right side* flange size:	*Left side* flange size:
		Combined output in ounces *per session*:	
		Are you feeling any discomfort while expressing? ☐ Yes ☐ No	
		Do you need assistance ordering a breast pump? ☐ Yes ☐ No	
Approx. how many feeds in 24hr?	Approx. how long is each feed?	What nipple products are you using? *(lanolin, nipple cream, nipple everter, Soft shells, Therashells, Hydrogel pads, Silverettes, reusable nipple pads, etc.)*	
What is your favorite nursing position?		►	
Do you often feed both sides?		►	
Are you waking at night to nurse or express? ☐ Yes ☐ No		►	
Are you familiar with hand expression? ☐ Yes ☐ No		Pacifier used? ☐ No ☐ Yes ☐ Sometimes ☐ Not Anymore	
What is your long term goal when it comes to lactation? How do you feel you are meeting your goals so far? ►		Have you *used* or *are you using* a nipple shield? ☐ Yes ☐ No	
		Do you use the nipple shield on both sides? ☐ Yes ☐ No	
		Do you use the nipple shield every feed? ☐ Yes ☐ No	
Are you familiar with safe handling / storage of human milk and how to properly wash pump parts and bottles? ☐ Yes ☐ No		Are you using any alternative methods of infant feeding? *(Choose all that apply)* ☐ Bottle ☐ Cup Feeding ☐ SNS ☐ Syringe Feeding ☐ Finger Feeding ☐ Spoon Feeding ☐ Special Needs Feeder ☐ Introduction of Solids	
Would you like information on how to become certified milk donor? ☐ Yes ☐ No			

Rate your pain/discomfort while **nursing** *1 (None) and 5 (Unbearable)* ○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Rate your pain/discomfort while **pumping** *1 (None) and 5 (Unbearable)* ○ 1 ○ 2 ○ 3 ○ 4 ○ 5

List of Parental Medications / Vitamin / Herbal Supplements ▼	List of Infant Medications / Vitamin / Herbal Supplements ▼
List: Name, Dose, Frequency	*List: Name, Dose, Frequency*
►	►
►	►
►	►
►	►
►	►

Milk Production Risk Factors ▼

Check *all* below that pertain to you, *even if you previously answered above*:

- ☐ I had a cesarean birth.
- ☐ I was given pitocin in labor/postpartum.
- ☐ I was seperated from my baby.
- ☐ My postpartum bleeding is heavy and I am filling pads quickly.
- ☐ I experienced a postpartum hemorrhage.
- ☐ I am using hormonal contraception or estrogen containing products.
- ☐ I am often feeling tired, depressed, or have negative thoughts.
- ☐ I regulary smoke or use nicotine/tobacco products.
- ☐ My breast pump has been previously used.
- ☐ I am using a wearable pump as my primary pump.
- ☐ I am pump dependant.
- ☐ I am using a nipple shield.
- ☐ I have inverted nipples.
- ☐ I stopped nursing or expressing for a period of time.
- ☐ I am supplementing.
- ☐ My infant is sleeping through the night.
- ☐ My infant is starting to/is eating solid foods.
- ☐ I have my infant on a feeding schedule.
- ☐ I have been diagnosed with Diabetes Type 1 or 2.
- ☐ I have been diagnosed with a thyroid concern.
- ☐ I have been diagnosed with PCOS.
- ☐ I have underwent fertility treatment.
- ☐ I have chronic anemia.
- ☐ I have had breast/chest surgery.
- ☐ I have widely spaced breasts.
- ☐ My breasts are remarkablely different in size and/or shape.

What are your plans for work?

Have you discussed pumping/expression with your employer? ☐ Yes ☐ No

Have you been screened for postpartum mood disorders in the *last 14 days*? ☐ Yes ☐ No

Do you feel safe in your home? ☐ Yes ☐ No	Do you feel supported in your home? ☐ Yes ☐ No
Date of Completion:	**Client Signature:**