Lactation Intake Form

Mother's Name:_____ Today's Date:_____

Referred by: _____ Email address:_____

Are you currently seeing a Lactation Consultant? ☐ No ☐ Yes LC Name:_____

What is the reason for your visit today?

☐ Referral for Tongue-tie or Lip-tie assessment
☐ Sore or painful nipples and/or breasts
☐ Pumping and storing breast milk
☐ Other: _____
☐ Milk Supply Concerns (Over/Under Supply)
☐ Problems with latching baby onto the breast
☐ Engorgement or mastitis symptoms

Mother's Age/Date of Birth: _____
OB/GYN or Midwife: _____
Current **Medications,** Supplements, or Herbs:

_____

_____

Do you have any **medical issues** of which we need to be aware? ☐ No ☐ Yes (Please Explain)

_____

_____

Were your **periods** (before pregnancy) regular or irregular or absent? _____

Do you have a **history** of any of the following:

☐ Infertility treatment
☐ PCOS
☐ Speech Therapy
☐ Diabetes (☐ Type 1 ☐ Type 2 ☐ Gestational)
Controlled by ☐ Diet ☐ Medication ☐ Insulin
☐ Hypertension (☐ Chronic ☐ Pregnancy Induced)
☐ Thyroid issues_____
☐ Weight loss Surgery _____
☐ Breast Surgery_____
☐ Neck or Back Injury/Pain_____
☐ Anemia (low iron)
☐ Depression
☐ Food Allergies

Breast changes during pregnancy: __breast growth __darkening of areola __tenderness

Total Pregnancies _____ # of Living children_____
What is your current **goal**? _____
Have you ever breastfed before/other children? ☐ Yes ☐ No
How was that experience?_____

_____

_____

Baby's Name: _____
☐ Male ☐ Female
Where did you deliver:_____
☐ Vaginal birth ☐ C-Section ☐ VBAC
Date of Birth: _____
Gestational Age/weeks baby born at: _____
Current Age: _____
Birth Weight: _____lbs _____oz
Was baby admitted to **NICU**? ☐ Yes ☐ No
Does the baby have any **medical issues** of which we need to be aware? ☐ Yes (Please Explain) ☐ No

_____

_____

Baby's Doctor: _____

Feeding Information

Infant **Feeding Method**(s) ☐ Breast ☐ Bottle
☐ SNS ☐Syringe ☐ Cup
Baby is fed: ☐ breastmilk only ☐ formula only ☐ both
(Amount of supplemental formula_____)
Does baby take both breasts at each feeding?
☐ Yes ☐ No ☐ Sometimes ☐Baby not latching
Number of feedings in 24 hours_____
How long does the baby stay on the breast at each feeding?

_____

Does the baby use a **pacifier**? ☐ Yes ☐ No ☐ Some
diapers in the last 24 hrs? Wet(_____) Dirty(_____)

Pumping Information

Do you have a breast pump? ☐ Yes ☐ No
If yes, what kind of pump?_____
How often do you **pump**?_____
When did you begin pumping?_____
How much do you collect at each session?_____

I understand that a lactation consultation usually includes the following and consent for this and future consultations:

- Physical and visual examination of the mother's breasts and nipples
- Physical and visual examination of the baby, the babies mouth and the baby's suck
- Observation of breastfeeding and/or bottle feeding, pre and post feeding weigh in, and observation of pumping.
- Presentation of breastfeeding information, to include possible demonstration or graphical illustration

I give my consent for the lactation consultant to use clinical information obtained during our sessions for education of other health care providers and mothers about lactation. My baby and I won't be identified in any way, but aspects of our situation might be described and discussed.

I give permission for photographs and recordings to be made, of both me and my baby, for charting and clinical education purposes. If the photographs are shared in a clinical or educational context, identifying features or information will not be shown.

I grant permission to the Lactation Specialists at Adult and Pediatric ENT and Allergy of The Woodlands to share pertinent information about this and future consultations with my/our family physicians and health care providers, the referring person, my/our community breastfeeding helper(s), my/our insurance companies and to further the knowledge of breastfeeding. I/We understand that all medical care is to be provided by my/our own physician(s).

Name: _____ Signature:_____ Date: _____