TONGUE TIE/LIP TIE CONSULTATION INTAKE FORM

TODAY'S DATE_____
MOTHER'S NAME_____DOB_____
INFANT'S NAME_____DOB_____

IN YOUR OWN WORDS DESCRIBE ANY FEEDING PROBLEMS THAT CONCERNS YOU:_____
_____
_____
_____
_____
_____

HEALTH, PREGNANCY AND BIRTH HISTORY

DOES ANYONE ON EITHER SIDE OF THE BABY'S FAMILY HAVE ANY OF THE FOLLOWING?
(CIRCLE) food allergies environmental allergies asthma eczema hay fever breast cancer diabetes genetic disease thyroid disease alcoholism tongue tie
other_____

ARE YOU TAKING ANY OF THE FOLLOWING?
(CIRCLE). prenatals iron antihistamines pain pills aspirin cold remedies antibiotic laxatives diuretics antacids birth control pills diet pills fish oil stool softener probiotics herbs
(list:_____)
Other Rx/ supplements_____
DO YOU SMOKE? _____
CONSUME ALCHOL?_____ FREQUENCY?_____

HAVE YOU EVER HAD ANY OF THE FOLLOWING PROCEDURES RELATED TO YOUR BREASTS? (CIRCLE)
biopsy lumps implants chest tube breast reduction nipple problems
other_____

NUMBER OF PREGNANCIES:_____
NUMBER OF LIVE BIRTHS_____
NUMBER OF LOSSES_____
OTHER CHILDREN NAME(S) AND DATE(S) OF BIRTH:_____
PREVIOUS BREASTFEEDING ISSUES?
EXPLAIN:_____

DID YOU HAVE ANY OF THE FOLLOWING DURING THIS PREGNANCY?
(CIRCLE) preterm labor infection/fever gestational diabetes high blood pressure nausea/vomiting severe anemia other_____
DID YOU EXPERIENCE ANY POSTPARTUM COMPLICATIONS?
(CIRCLE) infection (type:_____) Low/high blood pressure excessive bleeding/ hemorrhaging retained placenta other_____
AFTER BIRTH DID THE BABY HAVE...?
(CIRCLE) breathing difficulties meconium aspiration low blood sugar jaundice (highest bili level_____) other_____

DOES YOUR BABY HAVE HEALTH PROBLEMS?
EXPLAIN_____
IS THE BABY CURRENTLY ON ANY MEDICATIONS? Y or N

_____

BREASTFEEDING HISTORY
WHEN DID BREASTFEEDING DIFFICULTIES BEGIN?

_____

DID YOU EXPERIENCE BREAST CHANGES IN PREGNANCY? Y or N
BREAST CHANGES SINCE THE BIRTH? hard/engorged heavy warm leaking no changes
WHAT WERE THE FIRST SEVERAL DAYS OF FEEDING LIKE?

_____

_____

WHAT DOES YOUR FEEDING ROUTINE LOOK LIKE NOW?

_____

_____

__ _____

HAVE YOU USED ANY BREASTFEEDING SUPPLIES OR PUMPS?
Y or N Type of PUMP_____ Frequency of pumping?_____
YIELD WHEN PUMPING (oz/mls per session)_____Flange size?_____
HAS YOUR BABY BEEN SUPPLEMENTED WITH ANY OF THE FOLLOWING?
NONE water/glucose water your expressed breastmilk donor milk formula (brand_____) other:_____
IF SO, HOW WAS THE BABY SUPPLEMENTED?
feeding tube finger feeding cup feeding bottle
TYPE of BOTTLE_____ Other_____
Pacifier? Y or N Type:_____
IF SUPPLEMENTING, HOW OFTEN IN PAST 24 HOURS? _____
HOW MUCH PER FEEDING?_____
HOW MANY TIMES IN THE PAST 24 HOURS HAVE YOU BREASTFED YOUR BABY?
(CIRCLE) less than 6 times less than 8 times 8-10 times more than 12 times
ARE YOU EXPERIENCING ANY OF THE FOLLOWING?
(CIRCLE) using a nipple shield latch-on difficulties engorgement sore nipples sleepy baby preference for one side baby not interested baby always seems hungry baby crying excessively cracked/ bleeding nipples breast pain feeling that there is not enough milk baby's active suckling less than 5 min/sleepy at breast
other_____
IS THE BABY CONTENT BETWEEN FEEDINGS?
(CIRCLE) never occasionally often
comments_____
WHAT IS THE AVERAGE TIME BETWEEN FEEDINGS?
DAY:_____hrs NIGHT:_____hrs
HOW LONG DOES A NURSING SESSION LAST?

_____

BABY TAKES: one breast both breasts
WHO DECIDES WHEN THE FEEDING IS OVER? Mother or Baby
HOW MANY MONTHS DO YOU WISH TO BREASTFEED YOUR BABY?
1 MONTH 2-3 MONTHS 3-6 MONTHS 6-9 MONTHS 12 MONTHS LONGER THAN 12 MONTHS
OTHER:_____

IS YOUR BABY...? GASSY. SPITTING UP HICCOUGHING
OTHER:_____
HOW WOULD YOU DESCRIBE YOUR GENERAL MOOD:
(select all that apply) happy sad depressed anxious nervous stressed foggy detached worried ecstatic fragile up&down exhausted overwhelmed. scared
other_____
PARTNER SUPPORTIVE? Y N

_____

Anything Else you want the Lip & Tongue Tie professional to know?

_____
_____
_____
_____