Cash Family Orthodontics

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NOTE: FOR CHILDREN BEYOND BREASTFEEDING AGE, YOU CAN SKIP QUESTIONS LABELED WITH AN *

Patient's Name: _____ Parent's Name:_____

Patients' DOB:_____ Today's Date: _____

Home Address:_____

Phone number: _____ Email:_____

Reason for today's visit:_____

Pediatrician's Name:_____

Are you currently working with a lactation consultants?* _____ If so, who?* _____

Is your child currently being seen by anyone such as chiropractors, craniosacral therapists, PT, OT, SLP, etc?

If yes, what type and with whom?_____

Who can we thank for your referral? _____

MEDICAL HISTORY

Birth weight:_____ Most current weight and date:_____

Allergies of any type:_____

Please list all medications being taken:_____

Was your child premature?_____ If yes, what was the gestational age at birth?_____

Does your child have any medical conditions of any kind?_____ If yes, please list:_____

_____

Has your child had any surgeries including previous lip or tongue revisions? _____ If yes, please list: _____

_____

BREASTFEEDING QUESTIONS

Was there difficulty with your baby properly latching at birth?*_____ If yes, please explain*:_____

_____

Are you exclusively breastfeeding or supplementing (pumped breast milk or formula)?*_____

Are you using a nipple shield?*_____ How would you rate your milk supply?*_____

OVER

NOTE: FOR CHILDREN *BEYOND* BREASTFEEDING AGE, YOU CAN SKIP THIS ENTIRE PAGE

BABY'S SYMPTOMS

How would you rate your baby's latch? (circle one)

5-no issues 4 -minor issues 3-major issues 2-breast damage 1-mostly using bottle 0-no latch

Does your baby fall asleep nursing?_____ How long do feedings last?_____

Does your baby frequently fall of the breast/lose latch while nursing?_____

Does you baby's top lip flange UP or does is curl UNDER during breastfeeding?_____

Does milk or formula lead out of your baby's mouth while feeding?_____

Does your baby exhibit reflux or frequently gassy?_____

Has your baby's weigh gain been ON the curve or BELOW it?_____

Do you notice a clicking noise while your baby is feeding, whether breast or bottle?_____

MOM'S SYMPTOMS

How much discomfort do you experience while breastfeeding? (circle one)

5-unbearable 4-OMG 3-moderately painful 2-not much 1-very low 0-none

Are your nipples lipstick shaped following feedings?_____

Have you experienced any cracking, bleeding, bruising to your nipples after feedings?_____

Is there severe pain when your baby attempts to latch?_____

Are you experiencing complete breast drainage?_____

Have you had or do you currently have mastitis?_____ Have you or baby had thrush?_____

Please briefly describe your goals with feeding or breastfeeding:_____

_____

Who referred you to our office today?_____