# Lactation Counseling Intake

Today's Date_____Mother's Name_____

DOB_____Phone_____Email_____

Baby's Name_____Baby's DOB_____

Adjusted age_____Birth weight_____Lowest weight_____On day_____

Current weight_____ Describe any feeding issues that concern you:

Breastfed in the last 24 hours: □ fewer than 6 times □ fewer than 8 times □ 8-10 times □ 12+ times

Supplies used: □ Nipple shield □ Lactaid □ SNS □ Everter □pump Type of Pump_____

Baby has been supplemented: □ breastmilk □ water □ formula (powder ready-to-feed concentrate)

Baby was supplemented using: □NG tube □finger/syringe □cup□bottle type_____

Frequency in past 24 hours:_____How much/feeding:_____

Are you experiencing any of the following: □ latch-on difficulties □ engorgement □ sleepy baby

□sore nipples □preference for one breast □baby not interested □cracked/bleeding nipples □breast pain

□perception of low milk supply □baby excessively crying □baby always hungry □feelings of sadness during let down □ Other- Describe:

Is the baby sleeping or content between feedings: □Never □ Occasionally □ Often □ Usually

Longest times between feedings: Day_____Night_____does baby wake to feed_____

Who decides when feeding is over:_____How long does baby nurse_____

On one of both breasts:_____Do Breasts soften:_____In the past 24 hours how many: Wet diapers:_____Stools:_____color and size of stools:_____

Did the baby have any of the following after birth: □ breathing difficulties □ high hermocrit

□ low blood sugar □ meconium aspiration □ jaundice highest bili level_____current level_____

Other:

Does baby have any known health problems:

Does baby use pacifier? Frequency_____ reason_____

How long do you plan to breastfeed your baby:_____

Returning to work:_____when:_____full time_____ part time_____

PREGNANCY COMPLICATIONS: □ difficulty achieving pregnancy □ premature labor □ anemia □ fever □ UTI □PIH □ Gestational Diabetes □ Hyperemisis □ Medications

other:

Did breast size change during pregnancy_____when_____Could you express colostrum during pregnancy:_____when_____

LABOR/DELIVERY □ P.R.O.M. □Pain Meds □drugs due to high blood pressure □epidural □antibiotics □drugs to induce or speed up labor for _____hours □ Hemorrhage how much_____

□IV fluids how long_____ other:

TYPE OF DELIVERY □vaginal □emergency Cesarean □ planned Cesarean gestational age of baby_____

Did you have any of the following during the birth:

□ labor totaled longer than 30 hours □episiotomy □breech □forceps delivery □ asynclitic □vacuum □pushing longer than 2 hours other:_____

POSTPARTUM COMPLICATIONS: □UTI □ infection Low/high blood pressure

Describe you birth experience:_____

_____

_____

_____

_____

Describe you breastfeeding experience for the first three days after birth:_____

_____

_____

_____

Does anyone in the baby's family have any of the following: □ food allergies □ asthma □ environmental allergies □ eczema □ hay fever □ breast cancer □ diabetes □ genetic disease □ thyroid disease other:_____

Age of first menstrual period: _____ □ regular □ irregular

How many pregnancies:_____how many children:____how many breastfed:____

Any difficulties breastfeeding previous children:_____

Are you using any of the following: □ Norplant □ birth control shot □ IUD □ Birth control Patch □ antihistamines □ cold remedies □ antibiotics □ iron □ Vit. D □ herbs □ fish oil □ aspirin □ laxatives □diuretics/water pills □ antacids □ pain pills □ anti-depressant other:_____

Have you ever had any of the following related to your breasts: □ biopsy □ lumps □ implants □ breast reduction surgery □ nipple problems other:_____

Do you presently have or have you ever had any of the following: □ anemia □ diabetes □ allergy/asthma □ heart disease □ polycystic ovarian syndrome □ hepatitis B □ high blood pressure □ liver disease □ thyroid disease □ cancer □ infertility □ abnormal pap smear □ kidney/bladder disease or infection □ yeast infections □ eating disorder □ depression □ tuberculosis □ hemorrhoids □ miscarriages □ constipation other:_____

Maternal diet: □ balanced □ high protein □ low fat □ vegetarian □ weight loss □ special diet

Appetite: □ Excellent □ good □ missing meals □ poor appetite □ smoker

Maternal health problem concerns:_____

Mother's Physician_____

Baby's Physician_____


# Consent for Breastfeeding Services

I grant my permission for breastfeeding counseling service to be performed but the undersigned lactation counselor. I understand that to learn how the breastfeeding counselor can help me, this visit may consist of the following: a medical history of me and my baby, a physical assessment of my breasts, and assessment of how my baby breastfeeds, the use of breastfeeding aid and equipment (if I am using any aids or equipment), helpful hints and other educational information to help e breastfeed.

Optional: During the visit I would like my support person to photograph this session for my own personal use. I understand that these photos or videos are not to be sold or released on the internet. The lactation counselor agrees to be photographed or videoed for my own personal education purposes.

I understand that all medical care for my baby and me is to be provided by our physicians(s) and health care providers.

I understand and agree that this information in this file will be kept for a period of seven years.

I accept responsibility for the breastfeeding support visits, equipment rental or purchase, regardless of insurance or other third party involvement.

I authorize the undersigned counselor to charge my credit card for services rendered.

Date:_____

Mother Name:_____ Signature:_____

Lactation Counselor: _____Signature:_____