Pediatric Supplemental Breastfeeding

Acct#:_____

Name of child_____ Todays Date:_____

Mothers name:_____ Current weight _____Current Height_____

Briefly describe your current breast feeding relationship or any difficulties you may be having:_____

_____

_____

_____

_____

Is your child currently breastfeed/formula/other? _____

Who are you consulting for lactation help?_____

List any concerns you have for your child: (Ex: weight gain, head shape, sleep, tongue tie, airway restrictions, other concerns)

_____ ❑(1) Mild❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Very Concerned

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List any tests, studies or medications since birth:

❑Tests/Studies: _____

❑Medications/supplements/probiotic:_____

❑Aids used to assist with feedings_____

If diagnosed with a tie has it been revised ❑Yes ❑No Who was provider:_____

What areas were revised:_____

Are you currently on any diet restrictions?❑Yes ❑No If yes, what? _____

Describe mothers intestinal health?_____

Is your child having difficulty with: ❑Bowel Movements #/day_____ Size/quality_____

❑ Staying latched ❑ Clicking ❑ Reflux ❑Swallowing ❑Let down ❑ Bottle ❑ Pacifier ❑ Cries With Loud Noises

❑ Nipple/Breast Shape or Size ❑ Crawling ❑ Rolling ❑ Tummy Time ❑ Age appropriate sounds ❑ Car seat ❑ Sleep

List any changes better or worse since last visit:_____

_____

_____

_____

Doctor or therapist notes:_____

_____

_____