Carithers
PEDIATRIC GROUP
Grow Strong. Grow Happy.

Lactation Consultation Intake Form - Initial

Please email completed form prior to appointment to ksnowden@thecarithersgroup.com

Breastfeeding Parent Information:

Legal Name _____Chosen Name (if different) _____

Parent's DOB_____

Baby's First and Last Name _____Weeks at Birth _____

Baby's Hospital/Center of Birth _____Baby's DOB _____

Support Person Information:

Legal Name _____ Chosen Name (if different) _____

Relation to breastfeeding parent _____

Breastfeeding Parent's Health History (please select all that apply)

Breastfeeding Parent's Underlying Conditions:

- Allergies
- Anemia
- Autoimmune disorder
- Breast surgery (cosmetic or other)
- Cancer
- Difficulty conceiving
- Eating disorder
- Food allergy or sensitivity
- GI disorder
- Heart Disease
- Hepatitis
- Infertility
- Insomnia
- Irregular Periods
- Vitamin D Deficiency
- Yeast Infections
- Other _____

This birth experience included:

- Induction
- Epidural
- Vaginal
- Vacuum
- Forceps
- Cesarean
- Significant Blood Loss
- Surrogacy
- Adoption
- Loss

Breastfeeding Parent's Health History continued (please select all that apply)

Did this immediate postpartum include any of the following for the baby?

- Meconium aspiration
- Deep suctioning
- Resuscitation
- Supplemental oxygen
- APGAR score below 6 at any point
- NICU stay
- Separation from parent
- Phototherapy (bili-bed/blanket)
- Supplementation: breast milk/ formula
  Reason: _____
  Method: Bottle/syringe/spoon/cup
- None

Did this pregnancy include any of the following?

- Anxiety
- BMI >30
- Depression
- Diabetes (Gestational or Other)
- High Blood Pressure: preeclampsia, eclampsia, chronic
- Hyperemesis Gravidarum
- Polycystic Ovarian Syndrome (PCOS)
- Sexually Transmitted Infection
- Thyroid Disorder: hypothyroid, hyperthyroid
- Known contraindications for breastfeeding
- No prenatal care
- Other _____
- None

Are you currently taking (or noting for future use) any of the following?

- Prescription Drugs _____
- Supplements _____
- Herbs _____
- Encapsulated Placenta
- Topical Estrogen or Progesterone Cream
- Other _____
- None

Are you currently using (or noting for future use) any of the following?

- Recreational Drugs
- Alcohol
- Cigarettes/Nicotine/Tobacco
- None

Lactation Experience

Do you have previous lactation experience? If yes, please explain.

- Yes _____
- No

Number of feedings in the past 24 hours: ____

Number of diapers in the past 24 hours (describe amount and color)

- Urine: _____
- Stool: _____

Skin-to-skin (select all that apply)

- None
- Within 1 hour of vaginal birth
- Within 2 hours of cesarean birth
- 1 to 2 hrs in the last 24 hrs
- 3 to 4 hrs in the last 24 hrs
- Greater than 4 hrs in the last 24 hrs

Pumping Details (if applicable)

- Brand/model _____
- Flange size _____
- Number of pumps in 24 hrs _____
- Pump session duration _____
- Volume collected per pump _____

Is there any additional information you would like to share to help us best serve you and your baby (ex: faith, family structure, pronoun preferences, stressors, etc.)?