

**Lactation Consultation Intake Form**

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.)?