

Blossom Breastfeeding Support CLIENT INTAKE FORM

DATE		BABY'S WEIGHT, PRE-FEED	
BABY'S AGE		Post (RT)	Post (LFT)
DOCTOR/MIDWIFE			
PEDIATRICIAN/FAMILY PHYSICIAN			
MOTHER			
NAME			AGE
ADDRESS			
CITY		STATE	ZIP
PRIMARY PHONE:		ALTERNATE PHONE	
EMAIL			
CURRENT MATERNAL MEDICATIONS/VITAMINS/HERBS			
MATERNAL HEALTH CONCERNS			
MEDICATION OR FOOD ALLERGIES			
PLEASE CIRCLE ALL HEALTH PROBLEMS, PAST OR PRESENT HIGH BLOOD PRESSURE PCOS HYPERTHYROIDISM ANEMIA YEAST INFECTION BREAST REDUCTION INFERTILITY ANXIETY/DEPRESSION ECZEMA DIABETES TONGUE-TIE BREAST ABNORMALITIES FLAT/INVERTED NIPPLES OTHER: (LIST)			
DO YOU SMOKE?		ALCOHOL CONSUMPTION	
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> N/A <input type="checkbox"/> OCCASIONAL <input type="checkbox"/> FREQUENT	
RETURNING TO WORK/SCHOOL?	IF YES, WHEN?	FULL OR PART TIME?	
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME	
PLANNING TO PUMP?	WHAT KIND OF PUMP DO YOU OWN?		
<input type="checkbox"/> Yes <input type="checkbox"/> No			

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Did you experience any postpartum complications? (circle all that apply): **high/low blood pressure, excessive bleeding/hemorrhaging, urinary or other infections, fever, antibiotics, retained placenta**

Please explain:

INFANT

NAME		DOB	Wks GESTATION
GENDER <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE		BIRTH WEIGHT	DISCHARGE WEIGHT
WHERE WAS BABY BORN? <input type="checkbox"/> HOME <input type="checkbox"/> TRANSFER		HOSPITAL NAME	
VAGINAL BIRTH/CESAREAN? <input type="checkbox"/> VAGINAL <input type="checkbox"/> CESAREAN		INDUCTION <input type="checkbox"/> YES <input type="checkbox"/> NO	EMERGENCY/PLANNED C-SECTION <input type="checkbox"/> EMERGENCY <input type="checkbox"/> PLANNED
EPIDURAL? <input type="checkbox"/> YES <input type="checkbox"/> NO	FORCEPS/VACUUM? <input type="checkbox"/> FORCEPS <input type="checkbox"/> VACUUM	BREECH? <input type="checkbox"/> YES <input type="checkbox"/> NO	LABOR COMPLICATIONS? <input type="checkbox"/> YES <input type="checkbox"/> NO
PLEASE EXPLAIN:			
DID BABY EXPERIENCE ANY OF THE FOLLOWING? BREATHING DIFFICULTIES LOW BLOOD SUGAR MECONIUM ASPIRATION JAUNDICE SUPPLEMENTATION PACIFIER NICU STAY FEVER TONGUE-TIE OTHER			
PLEASE EXPLAIN:			
IS BABY CURRENTLY RECEIVING FORMULA? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF SO, WHY?	
HOW MUCH/HOW OFTEN?			

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FAMILY/PERSONAL

OTHER CHILDREN, AGES, BF DURATION/COMPLICATIONS::

ALLERGIES

WHAT ARE YOUR BREASTFEEDING GOALS?

PLEASE FEEL FREE TO SHARE ANY OTHER THOUGHTS OR CONCERNS:

CONSENT FOR BREASTFEEDING CONSULTATION

I understand that this breastfeeding consultation may consist of the following: a medical history of me and my baby, a physical assessment of my breasts, an assessment of how my baby breastfeeds including an examination of his/her mouth and tongue, the use of breastfeeding aids and equipment, helpful hints and other educational information to help me breastfeed.

I authorize the lactation consultant to release the information gained during the consultation to my and my baby's health care provider(s). **I understand that all medical care for me and my baby is to be provided by my physician and my baby's physician.**

I understand that for this lactation consultation and all follow-up, the lactation consultant will protect the privacy of my personal health information as required by the Code of Ethics of the International Board of Lactation Consultant Examiners, the Standards of Practice of the International Lactation Consultant Association, and the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

I accept total payment responsibility at the time of service, regardless of insurance or other third party involvement. I will receive an invoice to submit to my insurance company for consideration of reimbursement.

MOTHER'S SIGNATURE

DATE

LACTATION CONSULTANT'S SIGNATURE

DATE