BREATHE babies + kids

Patient's Name:_____ Patient's DOB:_____ Patient's age:_____ Sex:____

Today's Date:_____ Parent's Name(s): _____

Primary Phone:_____ Email:_____

Address:_____ City, State:_____ Zip:_____

Insurance Subscriber DOB:_____ Insurance Subscriber ID:_____ Insurance Subscriber SSN: _____

Pediatrician's Name:_____

Are you currently working with a lactation consultant? ○Yes ○No

If yes, who and when?_____

Is your child currently being seen for other services? (chiropractic care, physical therapy, occupational therapy, craniosacral therapy, speech therapy, feeding therapy, osteopathy etc.) ○Yes ○No If yes, what type? _____

If yes, why and by whom?_____

If yes, when/total number of visits?_____

Do you have any concerns with your child's gross motor development? (rolling, sitting, crawling, etc.) _____

Does your child have a preference for turning or tilting his/her head? (in car seat stroller, while sleeping, etc.)_____

Are you concerned with your baby's head shape? _____

Is this your first child? ○Yes ○No Family history of tongue tie? ○Yes ○No

Has Dr. Pinto treated you or a family member in the past? ○Yes ○No If so, who/when? _____

How did you hear about our office? _____

Please summarize your main concerns/reason for visit: _____

MEDICAL HISTORY

Birth weight (lb/oz):_____ Most current weight (lb/oz):_____

List all current **maternal** medications/supplements:_____

List all current **child** medications/supplements:_____

Does your child have any allergies? (Food, medication, etc.) ○Yes ○No If yes, please describe: _____

Did your child receive Vitamin K injections? ○Yes ○No Are your child's vaccines up to date? ○Yes ○No

Does your child have any heart diseases? ○Yes ○No If yes, please describe: _____

Has your child had any surgeries? ○Yes ○No If yes, what type(s) and when: _____

Has your child had prior surgery to correct a tongue or lip tie? ○Yes ○No

If yes, what type(s) and where: _____

Does your child have any other medical conditions or health concerns? ○Yes ○No

If yes, please describe: _____

BREATHE babies+kids

PREGNANCY/LABOR HISTORY: ❍Normal or ❍High Risk

Birth Location: _____

Was your child premature? ❍Yes ❍No If yes, gestational age at birth: _____

Were there any additional stressors with labor? ❍Yes ❍No

Please select all that apply: ❍Vaginal birth ❍Long labor ❍Unplanned C-section ❍Planned C-section
❍Excessive pushing ❍Trauma from vacuum or forceps ❍Breech birth

Other (please explain): _____

Difficulty with latch after birth? ❍Yes ❍No

MODE OF FEEDING

Please describe your current mode(s) of feeding: _____

Are you currently breastfeeding? ❍Yes ❍No
If yes, please select: ❍Exclusively breastfeeding ❍Mix of breast/bottle feeding

How would you rate your milk supply? ❍Oversupply ❍Good ❍Fair ❍Poor

Do you have a history of breast surgery? ❍Yes ❍No

Are you currently using a nipple shield? ❍Yes ❍No

Are you using an SNS? ❍Yes ❍No

Is this your first time breastfeeding? ❍Yes ❍No ❍ N/A Other breastfed children/how long? _____

Are you currently bottle feeding? ❍Yes ❍No
If yes, what type of bottles? _____

Are you supplementing with pumped breast milk? ❍Yes ❍No How many bottles/ounces per day? _____

Are you supplementing with formula? ❍Yes ❍No How many bottles/ounces per day? _____

Type of formula: _____

Does your baby use a pacifier? ❍Yes ❍No

BABY'S SYMPTOMS

Does your baby CONSISTENTLY fall asleep while attempting to nurse? ○Yes ○No

Does your baby CONSISTENTLY slide off breast when latching/feeding? (Skip if N/A) ○Yes ○No

Does his/her upper lip CONSISTENTLY curl inward (does not flip out) when latched? ○Yes ○No

Does your baby CONSISTENTLY have his/her mouth open at rest? ○Yes ○No

Does milk or formula leak/spill out of mouth while feeding at breast/bottle? ○Yes ○No

Does your baby CONSISTENTLY experience colic symptoms? ○Yes ○No

Does your baby CONSISTENTLY become visibly frustrated at the breast/bottle? ○Yes ○No

Does your baby CONSISTENTLY exhibit reflux symptoms? ○Yes ○No

Is your baby CONSISTENTLY extremely gassy? ○Yes ○No

Does your baby CONSISTENTLY snore during sleep? ○Yes ○No

Does your baby CONSISTENTLY exhibit noisy/congested breathing? ○Yes ○No

Has your pediatrician noted slow or poor weight gain? ○Yes ○No

Have you done any pre- and post- feeding weight checks?

If so, what was the transfer rate: _____ounces per _____minutes ○Yes ○No

Does your baby CONSISTENTLY display gumming or chewing of your nipple while nursing? ○Yes ○No

Is there a CONSISTENT "clicking noise" while feeding? ○Yes ○No

Does your baby seem CONSISTENTLY dissatisfied after feeding sessions? ○Yes ○No

If not, please explain: _____

What is the average length of feeding time in minutes? ○Less than 15 ○15-30 ○30-45 ○45-60 ○60+

CHILD'S SYMPTOMS

Please fill out the following sections only if age-appropriate for your child.

Eating Solid Foods

Does your child…

Show little interest in food? ○Yes ○No

Hold food in his/her mouth for extended periods of time? ○Yes ○No

Swallow large chunks of partially chewed food? ○Yes ○No

Choke on solids or liquids? ○Yes ○No

Spit food out? ○Yes ○No

Have any digestive issues? ○Yes ○No

Spit up or throw up shortly after eating? ○Yes ○No

Speaking

Does your child have language or articulation difficulties or delays? ○ Yes ○No

If yes, please describe: _____

Is your child currently seeing a speech pathologist? ○ Yes ○No

Sleeping

Does your child…

CONSISTENTLY sleep with an open mouth at night? ○Yes ○No

CONSISTENTLY sleep noisily/restlessly? ○Yes ○No

CONSISTENTLY sleep with a pacifier? ○Yes ○No

Does your child CONSISTENTLY wake up through the night? ○Yes ○No

If yes, how many times per night is child waking? _____

If yes, how many nights per week is his/her sleep affected? _____

Please describe your current sleeping arrangement. ○Co-sleeping ○ In bassinet/crib

Breathing

Does your child…

CONSISTENTLY rest in an open mouth posture during the day? ○Yes ○No

CONSISTENTLY mouth-breathe during the day? ○Yes ○No

CONSISTENTLY exhibit a forward head posture? ○Yes ○No

Please describe any other disturbances to eating, speaking, sleeping, breathing:

_____

MOTHER'S SYMPTOMS (if breastfeeding)

Please rate your level of discomfort while feeding: ○None ○Very Low ○Low ○Medium ○High ○Very High

Are your nipples becoming creased/flattened/lipstick-shaped/blanched white after nursing? ○Yes ○No

If yes, please select: ○Right Side ○Left Side ○Both

Are your nipples becoming cracked, bruised, or blistered after nursing? ○Yes ○No

If yes, please select: ○Right Side ○Left Side ○Both

Are your nipples bleeding? ○Yes ○No

If yes, please select: ○Right Side ○Left Side ○Both

Is there any severe pain when your baby attempts to latch? ○Yes ○No

If yes, please select: ○Right Side ○Left Side ○Both

If yes, please select: ○Pain subsides after initial latch ○Pain persists throughout feeding

○Pain is felt in-between feeds

Are you experiencing poor or incomplete breast drainage? ○Yes ○No

Do you have a history of, or currently have, mastitis? ○Yes ○No

Do you have a history of, or currently have, nipple/baby oral thrush? ○Yes ○No

CONCERNS & GOALS

In a sentence or two, please share your current feeding concerns:

_____

_____

In a sentence or two, please share your feeding goals:

_____

_____

Medical Information Release Form (HIPAA Release Form)

NAME:_____ DATE OF BIRTH: _____

Release of information

[ ] **I hereby authorize** The Breathe Institute and affiliates to release my child's health/treatment records to the individuals below.
*We typically release appointment reports to the providers listed.

Parent/Spouse/ Relative _____

Referring Provider _____

Pediatrician _____

Lactation Consultant _____

Speech/Physical/Occupational Therapist _____

Bodyworker/Doula/Midwife/Other _____

(DESCRIBE INFORMATION NOT TO BE DISCLOSED, IF ANY)

[ ] **I do not authorize** The Breathe Institute or affiliates to release any medical information.

This **Release of Information will remain in effect until terminated by me in writing.*

Messages

Please call [ ] My Home [ ] My work [ ] My Cell # _____

If unable to reach me:

[ ] You may leave a detailed message

[ ] Please leave a message asking me to return your call

[ ] _____

The best time to reach me is (day)_____ between (time) _____

Signed:_____Date: _____

Witness:_____Date: _____