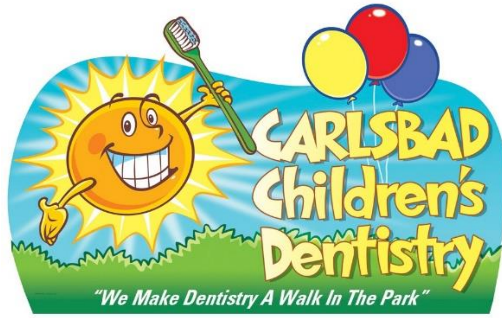
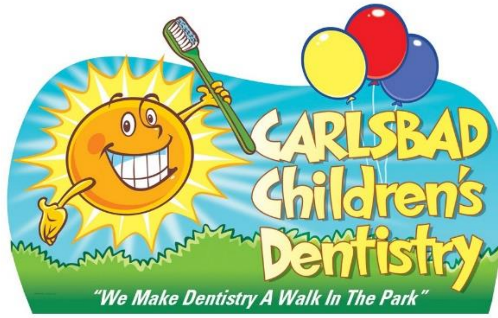


Patient's Name:___________________________ Patient's DOB:_________________ Patient's age:________ Sex:____
Today's Date: _______________Parent's Name(s):_______________________ Primary Phone:______________________
Address: ____________________________________City________ State_______ Zip:__________
Email:____
Insurance Subscriber DOB: ____________ Insurance Subscriber ID:_______________________
Insurance Subscriber SSN:_______________
Pediatrician's Name: ____
Are you currently working with a lactation consultant? O**Yes** O**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.) O**Yes** O**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 prefer 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? O **Yes** O **No** Family history of tongue tie? O**Yes** O**No**
Has Dr. Dabir treated you or a family member in the past? O**Yes** O**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.) O**Yes** O**No** If yes, please describe:____
Did your child receive Vitamin K injections? O**Yes** O**No**
Are your child's vaccines up to date? O**Yes** O**No**
Does your child have any heart diseases? O**Yes** O**No** If yes, please describe: ___________________________________
Has your child had any surgeries? O**Yes** O**No** If yes, what type(s) and when:____________________________________
Has your child had prior surgery to correct a tongue or lip tie? O**Yes** O**No**
If yes, what type(s) and where: ____
Does your child have any other medical conditions or health concerns? O**Yes** O**No**
If yes, please describe: ____



PREGNANCY/LABOR HISTORY: O **Normal** or O **High Risk** Birth Location: ___________________________

Was your child premature? O**Yes** O**No** If yes, gestational age at birth: _______________________________

Were there any additional stressors with labor? O**Yes** O**No**

Please select all that apply: O**Vaginal** birth O**Long labor** O**Unplanned C-section**

O**Excessive pushing** O**Trauma from vacuum or forceps** O**Planned C-section** O**Breech birth**

Other (please explain):____

Difficulty with latch after birth? O**Yes** O**No**

MODE OF FEEDING

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

Are you currently breastfeeding? O**Yes** O**No**

If yes, please select: O**Exclusively breastfeeding** O**Mix of breast/bottle feeding**

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

Do you have a history of breast surgery? O**Yes** O**No**

Are you currently using a nipple shield? O**Yes** O**No**

Are you using an SNS? O**Yes** O**No**

Is this your first time breastfeeding? O**Yes** O**No** O**N/A** Other breastfed children/now long? _______________

Are you currently bottle feeding? O**Yes** O**No** If yes, what type of bottles? __________________________________

Are you supplementing with pumped breast milk? O**Yes** O**No** How many bottles/ounces per day? _____________

Are you supplementing with formula? O**Yes** O**No** How many bottles/ounces per day? _______________________

Type of formula:____________________________________

Does your baby use a pacifier? O**Yes** O**No**

Baby's Symptoms

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

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

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

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

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

Does your baby CONSISTENTLY experience colic symptoms? O**Yes** O**No**

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

Does your baby CONSISTENTLY exhibit reflux symptoms? O**Yes** O**No**

Is your baby CONSISTENTLY extremely gassy? O**Yes** O**No**

Does your baby CONSISTENTLY snore during sleep? O**Yes** O**No**

Does your baby CONSISTENTLY exhibit noisy congested breathing? O**Yes** O**No**

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

Have you done any pre and post feeding weight checks? O**Yes** O**No**

If so, what was the transfer rate: _____ ounces per _____ minutes

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

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

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

if not, please explain: ____

What is the average length of feeding time in minutes? O**less than 15** O**15-30** O**30-45** O**45-60** O**+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 foods? O**Yes** O**No**

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

Swallow large chunks of partially chewed food? O**Yes** O**No**

Choke on solids or liquids? O**Yes** O**No**

Spit out food? O**Yes** O**No**

Have any digestive issues? O**Yes** O**No**

Spit up or throw up shortly after eating? O**Yes** O**No**

Speaking

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

if yes, please describe: ____

Is your child currently seeing a speech pathologist? O**Yes** O**No**

Sleeping

Does your child…

CONSISTENTLY sleep with an open mouth at night? O**Yes** O**No**

CONSISTENTLY sleep noisy/restlessly? O**Yes** O**No**

CONSISTENTLY sleep with a pacifier? O**Yes** O**No**

Does your child CONSISTENTLY wake up through the night? O**Yes** O**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 O**Co-sleeping** O **In bassinet/crib**

Breathing

Does your child…

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

CONSISTENTLY mouth-breathes during the day? O**Yes** O**No**

CONSISTENTLY exhibit a forward head posture? O**Yes** O**No**

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

____

Mother's Symptoms (If breastfeeding)

Please rate your level of discomfort while feeding: O**None** O**Very low** O**Medium** O**High** O**Very High**

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

If yes, please select: O**Right Side** O**Left Side** O**Both**

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

If yes, please select: O**Right Side** O**Left Side** O**Both**

Are your nipples bleeding?

If yes, please select: O**Right Side** O**Left Side** O**Both**

Is there any severe pain when your baby attempts to latch?

If yes, please select: O**Right Side** O**Left Side** O**Both**

If yes, please select: O**Pain subsides after initial latch** O**Pain persists throughout feeding** O**Pain is felt in between feeds**

Are you experiencing poor or incomplete breast drainage? O**Yes** O**No**

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

Do you have a history of, or currently have, nipple/baby oral thrush? O**Yes** O**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 (HIPPA Release Form)

Name: ___________________________________ DOB: ______________________________

Release of Information:

[ ] **I hereby authorize** Carlsbad Children's Dentistry 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 Carlsbad Children's Dentistry 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: _______________________________