NORTHEAST
LIP & TONGUE TIE
CENTER

Infant Assesment

Patient'sName_____BirthDate_____Today'sDate_____
Medical problems: __Heart Disease __Bleeding Disorders __Other__Male __Female Birth Weight_____ Present Weight_____ Birth Hospital_____
Vaginal Birth __C-Section Birth__ Any birth complications?_____

Medical History

Infants are usually given vitamin K at birth. Did your child receive the vitamin K shot: __Yes __No
Was your infant premature: __Yes __No –If yes, how many weeks?____
Does your infant have any heart disease? __Yes __No or Known bleeding diseases?___Yes ____No
Has your infant had any surgery? __Yes __No
Has your infant experienced any of the following? Please check all that apply

__Shallow latch at breast or bottle
__Falls asleep while eating
__Slides or pops on and off the nipple
__Colic symptoms/Cries a lot
__Reflux symptoms
__Clicking or smacking noises when eating
__Spits up often? Amount/Frequency____
__Gagging, choking, coughing when eating
__Gassy (toots a lot) / Fussy often
__Poor weight gain
__Hiccups often/a lot in utero
__Sucking blisters/ callouses on lips
__Gumming or chewing your nipple when nursing
__Pacifier falls out easily, doesn't like, won't stay in
__Milk dribbles out of mouth when nursing/bottle
__Short sleeping requiring feedings every 1-2 hours
__Snoring, noisy breathing or mouth breathing
__Baby moves a lot in sleep/ restless sleep
__Nose congested often
__Baby is frustrated at the breast or bottle
__How long does baby take to eat?_____
__How often does baby eat?_____
__Lip curls under when nursing or taking bottle
__Baby seems always hungry and not full

Is your infant taking any medications?___Reflux ___Thrush Name of medication:_____
Has your infant had a prior surgery to correct the tongue or lip tie: If yes, when, where and by whom:
_____
Do you have any of the following signs or symptoms? Please check all that apply

__Creased, flattened or blanched nipples
__Lipstick shaped nipples
__Blistered or cut nipples
__Bleeding nipples
Pain on a scale of 1-10 when first latching___
Pain on a scale of 1-10 during nursing_____
__Decreasing milk supply
__Poor or incomplete breast drainage
__Infected nipples or breasts
__Plugged ducts/engorgement/mastitis
__Nipple thrush
__Using a nipple shield
__Baby prefers one side over other__(R/L)
__Feelings of hopelessness/depression

Pediatrician:_____Phone number:_____
Lactation Consultant:_____Phone number:_____
Chiropractor/PT/ CST:_____ Phone number:_____
Other Therapist/ Provider_____Phone number:_____
When is your next follow up with your functional specialist? (IBCLC/PT/OT/CHIRO/CPST)_____