Nurturing Naturally, LLC – Client Intake Form – Please Print

	MOTHER	FATHER	BABY
FULL NAME			
NICKNAME			
DOB/AGE	/	/	
ADDRESS			# WKS GESTATION
HOME PHONE			PLACE OF BIRTH
CELL PHONE			BIRTH WEIGHT
E-MAIL			
OCCUPATION			☐ FEMALE ☐ MALE: ○ INTACT ○ CIRC

	MIDWIFE/OB-GYN	PEDIATRICIAN
PHYSICIAN NAME		
PRACTICE NAME		
ADDRESS		
CITY, STATE ZIP		
PHONE/FAX		

A REPORT WILL BE SENT TO YOUR MIDWIFE/OB-GYN OR PEDIATRICIAN.

FAMILY HISTORY	Yes	No	Details
Food or Drug Allergies?			
Asthma?			
Eczema?			
Breast Cancer?			

MATERNAL HISTORY	Yes	No	Details
Use Tobacco?			
Drink Alcohol?			
Use illegal drugs?			
PCOS/Fertility Problem?			
Diabetes?			
Thyroid Disease?			
Hormonal Birth Control?			
Previously Breastfed?			
Returning to Work?			

BREASTFEEDING GOALS AND CONCERNS:

How long do you plan to breastfeed?_____3 mos _____6 mos _____9 mos _____1 yr
_____1 ½ yrs _____2 yrs _____Child Led Weaning

MATERNAL CONCERN

- ❏ Painful feedings
- ❏ Low milk supply
- ❏ Mastitis/Plugged Duct Management
- ❏ Weaning from Nipple Shield
- ❏ Thrush
- ❏ Maintaining milk supply when returning to work
- ❏ Maintaining milk supply & starting solids
- ❏ Other Concerns:_____

INFANT CONCERN

- ❏ Low weight gain
- ❏ Breast Refusal/Returning to Breast
- ❏ Colic/Fussiness/Gassy
- ❏ Vomiting/Excessive Spitting Up
- ❏ Green stools/Diaper Rash
- ❏ Thrush
- ❏ Tongue Tie/Post Frenotomy

Based on the concerns you have, what is your goal? If a miracle happened and your concern was suddenly resolved, what would be the first thing you would notice that let you know the challenge had been overcome?

_____

_____

MATERNAL HISTORY

General Health:

Medications/Herbs/Vitamins/Supplements/Over-the-counter Medications:

Maternal Diet: ☐ Balanced ☐ High Protein ☐ Low Fat ☐ Vegetarian ☐ Vegan
Appetite: ☐ Excellent ☐ Good ☐ Missing Meals ☐ Poor
Prenatal cup size: _____ Postpartum cup size: _____

	Yes	No	Details
Breasts softer after feeding?			
Feeling at let down?			
Monthly breast self-exam?			

INFANT HISTORY

General Health/Birth Issues:

Medications/Herbs/Vitamins/Supplements/Over-the-counter Medications:

Pacifier Use: ☐ None ☐ <1 hr ☐ 1 – 3 hrs ☐ 3 – 5 hrs ☐ > 5 hrs

<u>THE LAST 24 HOURS</u>

Voids (pee) (5 – 6 by D5): _____ # Stools (poop)(3 – 5 by D5): _____
Breastfeeds: _____ ☐ One Side ☐ Both Sides
Pumps:_____ Yield per pump:_____ ☐ Per Side ☐ Total of both sides
Breastpump Type: ☐ Medela Pump-N-Style ☐ Medela Freestyle ☐ Avent Purely Yours
☐ Hygeia ☐ Hospital Pump ☐ Other: _____
Supplementation: ☐ Breastmilk ☐ Formula ☐ Other: _____
Amount _____ Times per day _____
☐ Cup ☐ Finger Feeder ☐ SNS ☐ Bottle – Type: _____
Where does baby sleep? ☐ Co-Sleeper/Crib Side Car ☐ Room Share Bassinette/Crib
☐ Bed Share ☐ Crib Own Room