# Holactic Health LLC

## Client Intake Breastfeeding Consultation Services

### MOTHER

LAST NAME | First Name | DOB / /

ADDRESS

CITY | STATE | ZIP

HOME PHONE | WORK PHONE

CELLPHONE | EMAIL

OCCUPATION

### FATHER

LAST NAME | FIRST NAME | DOB / /

OCCUPATION

### OB/GYN or NURSE MIDWIFE

LAST NAME | FIRST NAME | AGE

ADDRESS

CITY | STATE | ZIP

HOMEPHONE | WORKPHONE

### INFANT

LASTNAME | FIRSTNAME

D.O.B / / | WEEKS BORN

BIRTH WEIGHT

DISCHARGE WEIGHT

PRESENT WEIGHT

IF PREMATURE, HOW OLD IS YOUR BABY (IN WEEK S) NOW?

### PEDIATRICIAN FAMILY PHYSICIAN

LASTNAME | FIRSTNAME

ADDRESS

CITY | STATE | ZIP

PHONE

### BIRTHPLACE

☐ HOSPITAL NAME

☐ BIRTH CENTER NAME

☐ HOME

REFFERED BY

### REASON FOR CONSULTATION

| MOTHER | INFANT |
|---|---|
| ☐ Sore nipples/breasts | ☐ Help with latch on and positioning |
| ☐ Breast infection/management | ☐ Rubber nipple preference |
| ☐ care Engorgement | ☐ Preterm infant |
| ☐ Flat or inverted nipple(s) | ☐ Sleepy baby |
| ☐ Low milk supply | ☐ Weight gain problems |
| ☐ Working and breastfeeding | ☐ Fussy baby |
| ☐ Nutrition and breastfeeding | ☐ Allergies and breastfeeding |
| ☐ Other | ☐ Other |

**BREASTFEEDING CONCERNS:** _____

Why did you choose to breastfeed your baby?

| | |
|---|---|
| Did any of your relatives breastfeed their babies? | Yes Or No |
| Did you have any prior breastfeeding education? | Yes Or No |
| Breastfeeding books? If yes, what are their names? | Yes Or No |

| | |
|---|---|
| Have you attened any breastfeeding classes? | Yes Or No |
| LaLeche League meetings? | Yes Or No |
| Nursing Mother's Meetings? | Yes Or No |