Thrive New Client Information

Today's Date: _____ Infant's DOB: _____ Infant's Age: _____
Infant's Name: _____ Phone Number: _____
Parent's Name(s): _____ Email: _____
Address: _____ City, State: _____ Zip: _____
Pediatrician: _____ Lactation Consultant: _____
Chiropractor: _____ Craniosacral Therapist: _____
Other Body work specialist: _____
Is this your first child? _____
How did you hear about Thrive? _____

Infant's Medical History:

Birth Weight (lb, oz): _____ Most Current Weight (lb, oz) _____
Allergies: _____ Medications/Supplements: _____
Did your infant receive Vitamin K injection? _____
Does your infant have heart disease? _____
Has your infant had any surgeries? _____ What/when: _____
Has your infant had a prior tongue/lip tie release? _____
Does your infant have any medical conditions or health concerns? _____
If so, what type(s)? _____

Pregnancy/Labor History (Circle one): Normal Risk or High Risk

Birth Location: _____
Was your infant premature? _____ Gestational age at birth: _____
Were there any additional stressors with your labor. (circle all that apply)?
Long labor Excessive pushing Breech birth Unplanned c-section
Trauma from vacuum or forceps Other: _____
Did you experience difficulty with latch after birth? _____
Is this your first time breastfeeding? _____
Other breastfed children, how long? _____
Are you supplementing with formula? _____
If yes, how many. Bottles/ounces per day? _____
How would you rate your milk supply (circle one): Oversupply Good Fair Poor
Does your infant seem satisfied after nursing? _____
Average length of time feeding at the breast (min): <15 15-30 30-45 45-60 >60
How often is your infant eating? _____

Infant Symptoms:

___ Falls asleep while attempting to nurse
___ Slides/pops off breast when feeding
___ Shallow latch
___ Upper lip curls under when nursing or taking bottle
___ Pacifier falls out easily/doesn't like pacifier
___ Snoring/ noisy breathing/ mouth breathing
___ Mouth is open at rest
___ Milk leaks out of mouth while feeding
___ Colic symptoms/cries a lot
___ Spits up often, amount/frequency: _____
___ Gagging/choking/coughing when eating
___ Frequent hiccups
___ Becomes visibly frustrated at the breast
___ Prefers one breast over the other
___ Reflux symptoms
    ___ Diagnosed with reflux by a pediatrician?
___ Gassy
___ Slow or poor weight gain
    Have you done any pre/post feeding weight checks? _____
    If so, what was the transfer rate? _____ oz per _____ minutes
___ Gumming or chewing on nipple while nursing
___ Noticeable clicking noise while nursing, is it frequent? _____

Mother Symptoms:

Level of discomfort when first latching (1-10): _____
Level of discomfort during nursing (1-10): _____
___ Creased, flattened or blanched nipples
___ Lipstick shaped nipples
___ Blistered or cut nipples
___ Bleeding nipples
___Poor or incomplete breast drainage
___ Infected nipples or breasts
___ Plugged ducts/ engorgement/ mastitis
___ Using a nipple shield

What are your current breastfeeding concerns? _____
_____

What are your breastfeeding goals? _____
_____