STRATFORD
Chiropractic
&Wellness
CENTRE

Dr. Mike Chambers | Dr. Tanya Chambers | Dr. Blair Neely | Dr. Sarah MacArthur
288 Wellington Street Stratford, ON N5A 2L9 | Phone: (519) 273-9200
Email: info@stratfordchiropractic.com | www.stratfordchiropractic.com

Breastfeeding Consultation Form (Child History)

Please take a few moments to complete this questionnaire for your child. If you need help with this form, please do not hesitate to ask. Thank you!

Personal Information

Child's Name_____Gender ☐M ☐F Date_____

Mother/Guardian_____Father/Guardian_____

Siblings names & ages_____

Date of Birth D_____M_____Y_____ Age _____

Address _____
City/Prov._____Postal Code _____
Best Phone# (_____)_____
Mother's E-Mail address _____

Referrals are our highest compliment; please share with us where you heard about our office:

☐ Current patient/a friend – name:_____
☐ Website ☐ Google search ☐ Social Media (FB/IG) ☐Yellow Pages ☐ Breastfeeding Buddies
☐ Family Doctor _____ ☐ Midwife _____
☐ Other - please specify_____

Birth History

Birth weight:_____ Birth length:_____ Arrival time: _____wks

Position at birth: ☐ Vertex (head down)☐ Breech (bum down) ☐ Posterior (face-up) ☐ Transverse ☐ Face first

Was labour: ☐ Spontaneous OR ☐ Induced → ☐ Membranes ruptured ☐ Cervical gel ☐ Pitocin

Any Interventions used? ☐ Forceps ☐ Vacuum extraction ☐ Manual pulling by doctor ☐ Epidural ☐ None

Type of Birth: ☐ Vaginal ☐ C-Section Duration of labour: _____

Location: ☐ Home ☐ Hospital Assisted by: ☐ Midwife ☐ Doctor

Apgar scores (if known): _____ _____

Any complications during/after delivery? ☐ None ☐ Bruising of face/head ☐ Respiratory distress

☐ Other _____

Any problems during pregnancy with this child? ☐ Fall onto buttocks ☐ Low back pain

☐ Gestational diabetes ☐ Hypertension ☐ Car accident ☐ Other _____

Has this child ever been to a Chiropractor? □ No □ Yes Name of previous Chiropractor & city_____
Approximate date of last visit: _____

Has this child ever had any x-rays taken? □ No □ Yes Of what area(s)?_____
Has this child ever been hospitalized or had any surgical operations? □ No □ Yes _____
Has this child ever been prescribed antibiotics? □ No □ Yes _____
Has this child ever been prescribed any other medications? □ No □ Yes _____
Does this child currently take any natural supplements? □ No □ Vit D □ probiotics Other_____
Does this child have any medical conditions or other health challenges? □ No □ Yes _____

Please rate the quality of this child's sleep: □ Poor □ Fair □ Good □ Excellent
Number of sleeping hours at night: _____ Number of napping hours during the day: _____

Has this child been exposed to second hand smoke? □ No □ Yes _____
Is mother a smoker? □ No □ Yes Is father a smoker? □ No □ Yes

Does mother currently take any medications? □ No □ Yes _____
Does mother have any conditions affecting her hormones? Thyroid, PCOS, Endometriosis? _____

Has mother breastfed a previous child? For how long?_____

Has this baby been assessed for Tongue Tie or Lip Tie? If so, by who?_____
Results:
Is this baby currently being fed with a bottle at all? □ No □ Yes – Breastmilk or Formula?
Is the bottle being used to supplement after a feed at the breast? □ No □ Yes
Is this baby using a soother? □ No □ Yes Is this baby using a nipple shield to latch? □ No □ Yes
Is mother having nipple pain with breastfeeding? □ No □ Yes _____
Has mother experienced any blocked ducts? □ No □ Yes Mastitis? □ No □ Yes
Have you consulted with another lactation professional? When? _____

Please describe your challenges with breastfeeding/ Why you are here _____
_____
_____
_____
_____

Notes:

Consent to Examination

As with any medical procedure or assessment your child undergoes, it is important to be fully informed about the type of procedure and the benefits and risks associated with that procedure.

By signing below, you are agreeing to have you (the mother) and your child examined by Dr. Tanya Chambers at Stratford Chiropractic & Wellness Centre. The purpose of this examination is to assist with difficulty breastfeeding. The examination may include but not be limited to manual hands-on palpation (touching) of the child's body (face, jaw, mouth, and spine) and the mothers body (specifically breasts). The exam may also include a chiropractic examination, which is a "hands-on" approach so that we can best assess your child's health.

_____
Child Name

_____ _____ _____
Parent/Guardian Name Parent/Guardian Signature Date

_____
Doctor Witness Signature