Lactation QUESTIONNAIRE

Parent's Name _____ Today's Date _____

Baby's Name _____ Baby's Date of Birth _____

Street Address _____

City _____ State _____ Zipcode _____

Phone _____ Email _____

Please describe in detail any challenges you are currently facing in your feeding journey. Include when these challenges began and what seems to make them better and/or worse.
Partner's concerns or questions?

Method(s) of feeding: ☐ Breastfeeding ☐ Bottle feeding

If bottle feeding: ☐ Expressed breast milk ☐ Formula: _____

How many times a day does your baby nurse: ☐ More than 8x/day ☐ Fewer than 8x/day

When your baby is nursing can you hear him/her swallow?	☐ YES	☐ NO
Did your milk "come in" by the third day?	☐ YES	☐ NO
Do your breasts feel softer after nursing?	☐ YES	☐ NO
Does your baby nurse during the night?	☐ YES	☐ NO
Does your baby wake up to nurse on his/her own before 3 hours have passed?	☐ YES	☐ NO
Does your baby have at least 4 bowel movements per day?	☐ YES	☐ NO
Are the bowel movements yellow?	☐ YES	☐ NO
Does your baby have at least 6 wet diapers per day?	☐ YES	☐ NO

If no, how many wet diapers in the past 24 hours: _____

Does your baby sleep soundly between some feedings?	☐ YES	☐ NO
Does your baby have some fussy times?	☐ YES	☐ NO

Do you take any medications (prescription or over-the-counter) or herbal supplements? If yes, which ones:

Do you give your baby anything beside breastmilk or formula? Examples: water, herb teas, juice, etc.

LABOR & DELIVERY

☐ Vaginal birth ☐ Scheduled C-section ☐ Emergency C-section

Please check any applicable interventions or complications:

☐ Breech
☐ Induction
☐ Pitocin to stimulate labor
☐ Steriods before/during labor
☐ Antibiotics during labor
☐ Pain medications
☐ Epidural
☐ Episiotomy
☐ Vacuum extraction
☐ Forceps

Did infant experience any complications in the hospital? Ex: Low blood sugar, jaundice, beta strep +, respiratory distress, need for supplementation

MATERNAL HISTORY

Please check any of the following you have been diagnosed with:

☐ Preeclampsia
☐ Thyroid problems
☐ PCOS
☐ Depression
☐ Anxiety
☐ High blood pressure
☐ Diabetes

Any history of breast surgery, breast injury, or breast abnormality? ☐ YES ☐ NO

If yes, please explain and indicate bilateral, left breast only, or right breast only.

Ages of any other children: _____

Future plans: ☐ Stay home ☐ Return to work when infant is _____ months old.

Signature: _____ Date: _____

INNATE HEALTH CHIROPRACTIC

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