First Latch & Counseling, Inc.

INTAKE FORM

Date ___________________

Parent's Name ____ Date of Birth _____________

Address ____

City/State/Zip Code ____

Home Phone ______________________________ Cell Phone ________________________________

Email ____

Occupation ____

Will you be returning to work/school? When? ____

Spouse/Partner's Name ______________________ Cell Phone ________________________________

Allergies? ☐ No ☐Yes Please explain: ____

Smoke Cigarettes? ☐ No ☐ Yes

Family history of orthodontal interventions, and/or speech or feeding issues? ☐ No ☐ Yes

Reasons for your appointment? Please be specific. ____
____
____
____

What solutions or interventions have you used to assist you with your problems? __________________
____
____
____

MATERNAL BIOPSYCHOSOCIAL HISTORY

of Living Children ____________ # of Pregnancies ____________ # of Births _____________

Allergies? ☐ No ☐Yes Please explain: ____
____
____
____

Smoke Cigarettes? ☐ No ☐ Yes # of years ______ # per day ______

Alcohol? ☐ No ☐ Yes Frequency: ____

Marijuana/Narcotics? ☐ No ☐ Yes Frequency/Type: ____________________________________

MEDICAL HISTORY ("X" only if applicable)

☐ polycystic ovarian syndrome (PCOS)
☐ infertility
☐ thyroid problem
☐ diabetes (including gestational)
☐ anemia

☐ hormonal disorder
☐ irregular periods
☐ high blood pressure
☐ low blood pressure
☐ pre-eclampsia
☐ severe swelling in pregnancy/after birth

☐ depression
☐ anxiety
☐ eating disorders
☐ herpes virus
☐ HIV/AIDS

☐ other: ____
____

Current prescriptions or over-the-counter medications: ____
____
____

BREAST HISTORY

☐ Augmentation: Date of surgery ____/____/______ ☐ Reduction: Date of surgery ____/____/_____

☐ Accident/Injuries/Burns ____

If you have more children please describe their breastfeeding history: ____________________________
____
____
____

BIRTH INFORMATION

☐ Birthing Center ☐ Home (☐Planned/☐Unplanned) ☐ Hospital Doula at birth ☐ No ☐ Yes

Was your conception medically assisted? ☐ No ☐ Yes (Please explain) __________________________
____

Describe your pregnancy: ☐ Normal ☐ Difficult (Describe complications) ___________________
____

TYPE OF DELIVERY

Induction ☐ No ☐ Yes ☐ Vaginal ☐ Vacuum Assisted ☐Forceps ☐ Episiotomy

hours in labor _____________ ☐ C-Section ☐Planned or ☐ Emergency

MEDICATION USED DURING LABOR/DELIVERY

☐Epidural ☐Spinal ☐Pitocin ☐IV Medication ☐Antibiotics ☐ IV Fluids

☐ IV Fluids within 2 hours of the birth ☐Other pain medications _______________________________

DELIVERY COMPLICATIONS

☐ Failure to progress ☐ Fetal distress ☐ Maternal distress ☐ Hemorrhage following birth

☐ NICU admission ☐ Other ____

BABY HISTORY

Name ____ Date of Birth ____________

Delivered at gestational age ________weeks _______days Birth Weight _______________________

Lowest Weight _________________ Current Weight _________________ as of _____/_____/ _____

of **wet diapers** in 24 hours __________ # of **dirty diapers** in 24 hours ___________

Jaundice ☐ No ☐ Yes (highest Bilirubin ______)

Describe any additional important information about your baby: ________________________________

____

After birth were you and your baby separated? ☐ No ☐ Yes Please explain: ___________________

____

Was baby rooming in at the hospital? ☐ No ☐ Yes

☐ Postpartum doula at home ☐ Baby nurse at home during day/night

Are you using a pump? ☐ No ☐ Yes Are you using pacifiers? ☐ No ☐ Yes

HEALTH CARE PROVIDER INFORMATION

Midwife/OBGYN ______________________________________ Phone __________________________

Address ____

City/State/Zip Code ____

Pediatrician's Name ___________________________________ Phone __________________________

Address ____

City/State/Zip Code ____

INSURANCE INFORMATION

Insurance Provider: ____________________________________ ID # of Mother ___________________

ID # of Baby (if baby is 28 days or older) ____

Are you interested in attending support group for new mothers? ☐No ☐ Yes

Are you interested in individual or family counseling sessions? ☐ No ☐ Yes

How did you find out about The First Latch & Counseling, Inc.? ___________________________________