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

Age at **first** menstrual period_____

Age/length of time on hormonal birth control
_____
Pill_____ IUD _____
Injection _____

☐ 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
hours in labor _____

☐ Vaginal ☐ Vacuum Assisted ☐Forceps ☐ Episiotomy
☐ 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.? _____

Jennifer Leopold, IBCLC, LMSW Tova Ovits, IBCLC Chaya D. Stern, IBCLC, RN Stephanie Minnich, CBC