healthy kids nurtured by nature

New Patient Medical
Tongue & Lip Tie Release

General Information

Patient Name: _____ M / F DOB: _____/_____/_____
Mothers Name: _____Fathers Name: _____
Address: _____Post Code:_____
Home Phone: _____Work Phone: _____
Email: _____ _____Mobile: _____
Name of Physician: _____ Phone No: _____
Who is your Lactation Consultant / Health Nurse / Midwife? _____

Who can we thank for referring you?

_____

Pregnancy History

This information is collected to understand your child's growth, development and health.
What number baby/ child is this for you?
Any medications/drugs/ supplements taken prior to and /or during pregnancy? Please circle Yes No
If so: _____

Please circle your answers

What was your average stress level during pregnancy?	Low	0	1	2	3	4	5	High
Rate your level of fear about labour?	Low	0	1	2	3	4	5	High
Rate emotional stress? Eg. Lost loved one/moving house or location	Low	0	1	2	3	4	5	High
Rate depression levels experienced?	Low	0	1	2	3	4	5	High
Rate anxiety levels experienced?	Low	0	1	2	3	4	5	High
Did you feel supported by family and friends during pregnancy?	Low	0	1	2	3	4	5	High

Birth History

Please describe your child's birth.

please circle your answers

Was your child born: Vaginally Unassisted Assisted Forceps Vacuum Emergency Planned C-Section Induced
Gestation at Birth _____weeks Birth Weight: _____ Current Weight: _____
Was/ were the following drugs used?
Oxytocin / Syntocinon Spinal Anaesthesia Epidural Spinal Block Narcotics (Pethidine/ Morphine) Gas
Did the mother need medical support after labour? Yes No Details: _____
Did the child recover well after birth? Yes No Details: _____
Did the child wake to feed itself? Yes No
0-14 days how long was their sleep? <1 hr block 1-2hrs 2-3hrs 3+hr blocks
Has your child been examined for development, posture, activity levels, and physical stress? Eg. Muscle tone, postural habits, arching of head? Yes No Details: _____
After birth was your child examined for tongue and lip tie? Yes No
If so, by: _____(profession) _____(name) _____(practice) _____
Has your child had their lip and/or tongue tie previously released? Yes No
If so, by: _____(profession) _____(name) _____(practice) _____
Have you consulted with any other health professionals/ or community support network? Yes No
If so, by: _____(profession) _____(practice) _____
What was the proposed support? _____

Health History

Has your child experienced any of the following problems or treatment?

Please circle your answer

Received Vitamin K injections?	Yes	No	Is your child a mouth breather?	Yes	No
Does your infant have heart disease?	Yes	No	Has your infant had any surgery?	Yes	No
Ear infections or tonsillitis?	Yes	No	Skin rashes, eczema or dermatitis?	Yes	No
Any milk or food intolerances /allergies?	Yes	No	Poor weight gain?	Yes	No
Swallowing /breathing issues?	Yes	No	Upper respiratory infections?	Yes	No
Nasal obstruction?	Yes	No	Diarrhoea / Constipation?	Yes	No
Cyanosis (turning blue)?	Yes	No	Bleeding problems?	Yes	No

If so details: _____
Is your infant taking any medications or supplements? Yes No
If yes, please list _____

Development / Nutrition
Please circle your answer
What was your child's first milk (0-6 weeks)? breast only formula both
How did he/she initially feed? breast bottle tube feeding both
How is your child fed now? _____
If mother and child experienced breastfeeding challenges please provide details: _____
_____
Has your child commenced eating solids? Yes No
are they experiencing any issues (for example: gagging, swallowing, fussy about texture)? Yes No
If so, details: _____
Is your child reaching milestones within anticipated time frames? Yes No
If no, details: _____

Has your child experienced any of the following?
Please circle your answers

- Poor latch / difficulty latching to breast and/or bottle
- Makes clicking noise when suckling
- Fussiness and arching away from the breast
- Short sleep episodes requiring feeds every 1-2 hours (day and night)
- Falls asleep when nursing without finishing full feed
- Gumming or chewing of the nipple/teat when nursing
- Unable to maintain breast tissue or pacifier in mouth
- Slides on and off nipple when attempting to latch
- Choking on milk or popping off breast to gasp for air
- Reflux/Colic Symptoms
- Excessive drooling
- Heavy breathing / Snoring / Grinding
- Explosive, frothy bowel motions

Have you experienced any of the following symptoms
Please circle your answers

- Creased, flattened or blanched nipples after nursing
- Bleeding Nipples
- Cracked, bruised or blistered nipples
- Infected nipples or breasts
- Severe pain when your infant attempts to latch or suckle
- Poor or incomplete breast drainage
- Mastitis or blocked duct
- Nipple thrush
- Using a nipple shield
- Low or compromised milk supply
- Are you expressing milk or have you had to supplement your infant

Any Family History (that you are aware of)?
Please circle your answer
Tongue Tie Lip Tie

Do you have any other concerns that we have not included in the above that you would like to discuss further?

_____

_____

I understand that this information is correct to the best of my knowledge. I understand it will be held in the strictest confidence and only used to improve the quality of service my child receives. I further understand that payment is due on the day of my child's appointment.

Signature of Parent/Guardian:_____ Date: _____

Full Name of Parent/Guardian: _____