



TONGUE-TIE TEAM

INFANT ASSESSMENT SHEET

Today's Date _____

Infant's Name _____ Birth Date _____ Male Female

Birth Weight _____ Present Weight _____ Birth Location _____

Vaginal birth C-Section Birth Any birth complications? _____

Are you breastfeeding or pumping? Yes No If no, how long since you stopped breastfeeding? _____

1. Infants are usually given vitamin K at birth. Did your child receive the vitamin K shot? Yes No
2. Was your infant premature? Yes No If Yes, how many weeks? _____
3. Does your infant have any heart disease Yes No or known bleeding diseases? Yes No
4. Any other medical conditions? _____
4. Has your infant had any surgery? Yes No What type? _____

INFANT SYMPTOMS: Has your infant experienced any of the following? Please check / circle / elaborate as needed.

<input type="checkbox"/> Shallow latch at breast or bottle <input type="checkbox"/> Falls asleep in the middle of a feed <input type="checkbox"/> Slides or pops on and off the nipple <input type="checkbox"/> Gagging, choking, or coughing when eating <input type="checkbox"/> Poor or slow weight gain <input type="checkbox"/> Hiccups often <input type="checkbox"/> Lots of in utero hiccups <input type="checkbox"/> Gumming or chewing the nipple <input type="checkbox"/> Pacifier falls out easily or won't stay in <input type="checkbox"/> Snoring, noisy breathing, or mouth breathing <input type="checkbox"/> Short sleeping and waking often <input type="checkbox"/> Baby moves a lot in sleep/restless sleep <input type="checkbox"/> Baby seems always hungry and not full	<input type="checkbox"/> Lip curls under when nursing or taking bottle <input type="checkbox"/> Clicking or smacking noises when eating <input type="checkbox"/> Sucking blisters or callouses on lips <input type="checkbox"/> Colic symptoms / Baby cries a lot <input type="checkbox"/> Reflux symptoms <input type="checkbox"/> Spits up often? Amount / Frequency _____ <input type="checkbox"/> Gassy (toots a lot) / Fussy often <input type="checkbox"/> Milk leaks out of mouth when nursing/bottle <input type="checkbox"/> Nose sounds congested often <input type="checkbox"/> Baby is frustrated at the breast or bottle <input type="checkbox"/> Constipation or irregular stools How long does baby take to eat? _____ How often does baby eat? _____
---	--

6. Is your infant taking any medications? ___ Reflux ___ Thrush Name of medication: _____

7. Has your infant had a prior surgery to correct the tongue or lip tie? If yes, when, where, and by whom?

MOTHER SYMPTOMS: Do you have any of the following signs or symptoms now or in the past? Please check/elaborate.

<input type="checkbox"/> Creased, flattened, or blanched nipples <input type="checkbox"/> Lipstick shaped nipples <input type="checkbox"/> Blistered or cut nipples <input type="checkbox"/> Bleeding nipples Pain on a scale of 1-10 when first latching _____ Pain (1-10) during nursing _____	<input type="checkbox"/> Poor or incomplete breast drainage <input type="checkbox"/> Decreasing milk supply <input type="checkbox"/> Plugged ducts / engorgement / mastitis <input type="checkbox"/> Nipple thrush <input type="checkbox"/> Using a nipple shield <input type="checkbox"/> Baby prefers one side over other ___ (R/L) <input type="checkbox"/> Feelings of hopelessness / depression
---	--

Primary Care Provider Lactation Consultant: Who referred you to us:	Chiropractor/PT/CST: Other Therapist/Provider: ___ How far away do you live?
---	--

Doctor's Signature _____