



Intake Form

Baby's Name: Last _____ First _____

DOB: _____ Age _____ Gestation _____

Sex _____ Birth weight _____ Current weight _____

Mom's name: Last _____ First _____

Age _____ DOB _____ Occupation _____

Partner's name: Last _____ First _____

Age _____ DOB _____ Occupation _____

Address _____ Zip _____

Phone number(s) () _____

Email: _____

Primary Insurance: _____

Secondary Insurance: _____

Referred by _____

Pediatrician _____

OB/Midwife _____

Why have you requested this consultation?

Infant not latching on to the breast Mother nipple pain

Infant weight gain problem Maternal low milk supply

Other reason(s) _____

I grant permission to Milk and Honey, LLC to share pertinent information about this consultation with our family physicians and healthcare providers, the referring person(s), our community breastfeeding helper, and/or our insurance companies, to further the knowledge of breastfeeding. I also acknowledge that my IBCLC/Feeding Therapy may share pertinent information with other providers of Milk and Honey if necessary to collaborate and/or discuss as case studies. I understand that all medical care is to be provided by our own physicians.

_____/_____/_____
date

signature of mother/father

_____/_____/_____
date

signature of IBCLC&/or SLP