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 Therapisy 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