# 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 having difficulty latching
___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 provider