Intake Form

Baby's Name: Last _____ First _____
DOB _____ Sex _____ Baby's Age _____ Gestation _____
Birth Weight_____24-48 Hour Weight _____

Mom's name: Last _____ First _____
Age_____ Preferred pronouns _____ DOB _____ Occupation _____

Partner's name: Last _____ First _____
Age _____ Preferred pronouns _____ DOB _____ Occupation_____

Address _____ Zip_____
Phone number(s)_____
Email:_____
Mom Primary Insurance:_____
Baby Primary Insurance:_____
Mom Secondary Insurance: _____
Baby Secondary Insurance: _____
Preferred Pharmacy and Address: _____

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 parent date signature of provider

☐ By checking this box, I am acknowledging that I am electronically signing this form.