Baby's Name_____ Date of Birth:_____

Infant Feeding Caregiver Questionnaire

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http://www.myofunctionalspot.com/ ***www.lactationspot.com***

What are your primary feeding concerns (i.e- what lead you to seek this assessment)?

_____

_____

_____

_____

BACKGROUND

Birth History:

Vaginal / C-section birth

Need for intubation at birth: Y / N

Full term / Premature If premature, what was gestational age at birth? _____

Medical History:

Significant Medical History (Medical diagnosis, surgeries, illness, pregnancy/birth issues):

_____

_____

_____

Allergies:

_____

Specialists your baby sees: (ie- gastroenterologist, dietician, etc.):

_____

_____

Circle one:

Has your baby worked with a Physical Therapist?	Currently	Past	Never
Has your baby worked with an Occupational Therapist?	Currently	Past	Never
Has your baby worked with a Speech Therapist?	Currently	Past	Never
Has your baby done "body work" with a specialist?	Currently	Past	Never
Have you worked with a lactation consultant?	Currently	Past	Never

Mother's Medical History:

Significant Medical History (Medical diagnosis, surgeries, major or chronic illnesses, etc.):

_____

_____

_____

History of difficulty getting pregnant? Yes No

If yes, please explain:

_____

_____

Do you have a history of (circle all that apply): Breast reduction Breast Enlargement

Breast Surgery (any kind) Lung surgery Heart surgery Trauma to the chest

Have you been screened by a doctor for postpartum depression? Y N

Social History:

Siblings? Y N If yes, ages: _____

Do you have family or friends who help with baby? _____

Feeding History:

When did you first notice that your baby had feeding difficulties? _____

_____

Has your baby had a Modified Barium Swallow Study (MBSS)? N / Y If Y, when and what were the results? _____

History of reflux? Y N Not sure Does your baby have a G-tube? Y N

If Y for tube feeds, are they given using gravity OR pump? During the day / At night?

If Y for tube feeds, please list is the volume and frequency of feeds given through the tube? _____

CURRENT

My baby is: breastfed bottle fed both neither
Any difficulties not described above: _____

Any difficulties with breastfeeding: _____

_____

Any difficulties with bottle feeding: _____

_____

How many times a day does your baby eat? _____

Does your baby eat at night and if so, how often? _____

If bottle feeding, are you using pumped breastmilk, formula, or a mix? _____

Describe (estimates are fine if you don't know for sure) how much formula and/or breastmilk your baby is taking daily (in a 24-hour period? _____

If exclusively breastfeeding how many times a day and for about how long each time is baby nursing? _____

If offering formula, which brand are you using & how is baby tolerating? _____

_____

If pumping, how many times a day are you pumping and for how long and about how much milk do you express (on average)? _____

_____

History of reflux? _____

Have solids been introduced? Y N

If Y, what age were solid foods introduced? _____

Any issues not described above? _____

Please list all the people in your home who feed your baby (i.e.- mother, father, nanny, etc): _____

Does your baby have regular bowel movements? Y N If no, please explain:

_____

Any other comments/information that you feel would be helpful to this assessment:

_____

_____

_____