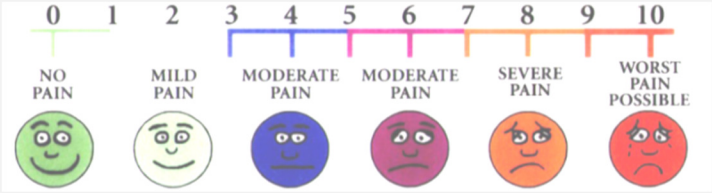
Patient Name: _____Sex:____
Date of Birth: _____
Today's Date: _____
Mother's name: _____
Mother's age: _____

Feeding Evaluation 0-12m (Follow-up)



What is your pain level when breastfeeding from 1-10?
On average, how many minutes is your baby on the breast per feeding?
In the last 24 hours, how many times did you breastfeed the baby?
In the last 24 hours, how many times did you bottle feed the baby?
If you bottle feed pumped breast milk, how many ounces?
If you bottle feed formula, how many ounces?
In the last 24 hours, how many times did you syringe feed the baby?

How Often:	Never	<25%	50%	>75%	Always
Does your child feed less than every 2 hours?					
Does your child sleep less than 2 hours between feedings?					
Does your child appear tired, fall asleep or get frustrated during feeding?					
Does the infant have a shallow latch?					
Does the infant click during breastfeeding?					
Does the infant latch on and off the nipple during breastfeeding?					
Does the infant tuck the lip under/in during breastfeeding?					
Does the infant choke/ gag during breastfeeding?					
Does the infant hiccup immediately after breastfeeding?					
Does the infant cough during breastfeeding?					
Do you feel the baby empties your breasts?					
Do you feel the baby is fussy right after feeding?					

How Often:	Never	<25%	50%	>75%	Always
How often does your child have excessive gas?					
How often do you have nipple pain during breastfeeding?					
Does the infant chew/ gum/ clench/ clamp down/ bite the nipple during breastfeeding?					
Do you notice blanching (fading/ whitening/ discoloration) of the nipples after breastfeeding?					
Does the infant spit up after breastfeeding?					
Do you see milk coming out of the nose after/ during feeding?					
Does the child arch his/ her back during/ after feeding?					
Do you use a nipple shield?					
Does your child leak from the corners of mouth during/after feeding?					

	YES	NO
Are your nipples cracked?		
Are you still doing the exercises?		
If no, how many days after the procedure did you do the exercises?		
How many times a day did you do the exercises		
What exercises were done? (Check all that apply)		
Finger sweeping		
Stretching the wound		
Tug of war		
Rubbing the gums		
Who did these exercises?		
How many days was the baby in discomfort after the procedure?		
How long did you use the pain medication after the procedure?		
What medications did you use?		
Did the baby breastfeed immediately after the procedure?		
If no, how many days after the procedure did the baby breastfeed?		
Did you work with IBCLC after the procedure?		
Did you work with a chiropractor, craniosacral therapist, or MFT?		