TMJ & Sleep
Therapy Centre

INFANT TONGUE/LIP TIE HEALTH QUESTIONNAIRE

Today's Date: ______________

Name: ______________ Birth Date: ______________ Born at: ______________ weeks

Age today: ______________ Adjusted age if premature: ______________ Gender: ☐ Male ☐ Female

Birth weight: ______________ Weight today: ______________ Average weight gain: ______________ oz per day

Name of Lactation Consultant: ______________ Number of visits: ______________

Name of Chiropractor or other Bodyworker: ______________ Number of visits: ______________

Obstetrician and/or midwife: ______________

Birth Hospital: ______________ ☐ Home Birth ☐ Vaginal Birth ☐ C-Section Birth

Any birth complications? ______________

Are you currently breastfeeding? ☐ Yes ☐ No

Are you currently bottlefeeding? ☐ Yes ☐ No

Did your child receive the Vitamin K shot at birth? ☐ Yes ☐ No

Is or was your baby diagnosed with Jaundice? ☐ Yes ☐ No

Does your infant have any heart disease? ☐ Yes ☐ No

Has your infant had any surgery? ☐ Yes ☐ No If yes, explain: ______________

Is your infant taking any medications? ☐ Yes ☐ No If yes, please list the name(s): ______________

Any other health conditions? ______________

Has your infant had a prior surgery to correct the tongue or lip tie? ☐ Yes ☐ No

If yes, when, where, and by whom? ______________

Has your infant experienced any of the following? Please check/circle/elaborate as needed.

___Shallow latch at breast or bottle
___Poor weight gain
___Falls asleep while eating
___Slides or pops on and off the nipple
___Hiccups often
___Lip curls under when nursing or taking bottle
___Colic symptoms/Cries a lot
___Reflux symptoms
___Clicking or smacking noises when eating
___Spits up often
___Gagging, choking, coughing when eating
___Gassy belly
___Baby is frustrated at the breast or bottle
___Gumming or chewing your nipple when nursing
___Milk dribbles out of mouth when nursing/bottle
___Snoring, noisy breathing or mouth breathing
___Nose congested often

How long does baby take to eat? ______________ How often does baby eat? ______________

Do you have any of the following signs or symptoms? Please check/circle/elaborate as needed.

___Creased, flattened or blanched nipples
___Lipstick shaped nipples
___Blistered or cut nipples
___Bleeding nipples
___Pain when first latching (1-10) ______
___Pain during nursing (1-10) ______
___Poor or incomplete breast drainage
___Infected nipples or breasts
___Plugged ducts/engorgement/mastitis
___Nipple thrush
___Using a nipple shield
___Baby prefers one side over other ______ (R/L)

Any additional concerns you have: ______________

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What is your number one goal with this evaluation? ______________

☐ I acknowledge that I have been offered a copy of the Office Privacy Notice and I am familiar with my rights as a patient of TMJ & Sleep Therapy Centre.
I understand this practice is Fee for Service Out-of-Network and regardless of my insurance coverage, I am responsible for any charges incurred at the time of my visit.

______________ Parent/Guardian Signature

______________ Parent/Guardian Printed Name

______________ Date