INFANT TONGUE/LIP TIE EVALUATION

This questionnaire has been compiled from multiple sources to best help us assess an infant patient's symptoms. Please fill out all questions to the best of your knowledge. This information will become part of the medical record and is considered confidential.

Today's Date: ___________

Child Demographic Information

Last Name: ___________ Middle Initial: ______ First Name: ___________

Gender: ☐ Male ☐ Female Date of Birth: ___________ Age: ______ Height: ______ ft ______ in Weight: ______ lbs

Address: ___________ Address 2: ___________

City: ___________ State: ______ Zip Code: ___________

Parent/Guardian Contact Information

Parent/Guardian Full Name: ___________ Relationship to Patient: ___________

Home Phone: ___________ Cell Phone: ___________ Work Phone: ___________

Email: ___________

Main Concerns

____

____

Provider Information

Pediatrician's Office: ___________ Last Visit: ___________

Doctor Name: ___________ Office Phone: ___________

City: ___________ State: ______ Zip Code: ___________

☐ I authorize communications and consent to release and/or obtain any of my information regarding my treatment with TMJ & Sleep Therapy Centre including a full report of examination findings, diagnosis, treatment plan and progress report between TMJ & Sleep Therapy Centre and the professional care team listed above.

Are you currently working with a lactation consultant? ☐ Yes ☐ No If yes, who? ___________

Is your infant currently being seen for bodywork (chiropractor, physical therapist, osteopath, occupational therapist, other)? ☐ Yes ☐ No

If yes, what type and by whom? ___________ Total Visits: ___________

Is this your first child? ☐ Yes ☐ No Family history of tongue tie? ☐ Yes ☐ No

Has TMJ & Sleep Therapy Centre treated you or a family member in the past? ☐ Yes ☐ No

If yes, who and when? ___________

Referral Information - how did you hear about us?

Referral Name/Source: ___________

Referral Type: ☐ Doctor ☐ Dentist ☐ Specialist ☐ Patient ☐ Other ___________

Patient/Guardian Initials: ______

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Medical History

Child's Birth Length: ______ ft ______ in Child's Birth Weight: ______ lbs ______ oz

Food allergies? ☐ Yes ☐ No If yes, which foods? ____________________

Medication allergies? ☐ Yes ☐ No If yes, which medications? ____________________

____

List all current maternal and infant medications/supplements: ____________________

____

Are vaccines up to date? ☐ Yes ☐ No

Did your infant receive Vitamin K injections? ☐ Yes ☐ No

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

Has your infant had any surgeries? ☐ Yes ☐ No If yes, what type(s) and when? ____________________

Has your infant had prior surgery to correct the tongue or lip tie? ☐ Yes ☐ No
If yes, what type(s) and where? ____________________

Does your infant have any other medical conditions or health concerns? ☐ Yes ☐ No
If yes, what type(s)? ____________________

Pregnancy/Labor History

Pregnancy: ☐ Normal ☐ High Risk Birth Location: ____________________

Was your infant premature? ☐ Yes ☐ No If yes, gestational age at birth: ____________________

Were there any additional stressors with labor? ☐ Yes ☐ No

Select all that apply: ☐ Long Labor/Excessive Pushing ☐ Breech Birth ☐ Unplanned C-Section ☐ Trauma from Vacuum or Forceps
☐ Other (please explain): ____________________

Difficulty with latch after birth? ☐ Yes ☐ No If yes, please explain: ____________________

Feeding/Nursing

Mode of Feeding: ☐ Bottle ☐ Breast

Is this your first time breastfeeding? ☐ N/A ☐ Yes ☐ No Other breastfed children/how long? ____________________

Are you supplementing with pumped breast milk? ☐ Yes ☐ No If yes, how many bottles/ounces per day? ____________________

Are you supplementing with formula? ☐ Yes ☐ No If yes, how many bottles/ounces per day? ____________________

Are you using SNS or any other supplementer? ☐ Yes ☐ No

Are you currently using a nipple shield? ☐ Yes ☐ No

How would you rate your milk supply? ☐ Oversupply ☐ Good ☐ Fair ☐ Poor

Mother's Symptoms

Please rate your level of discomfort while feeding or when you did breastfeed:
☐ N/A ☐ 0 - None ☐ 1 - Very Low ☐ 2 - Low ☐ 3 - Medium ☐ 4 - High ☐ 5 - Very High

Are you noticing your nipples becoming creased/flattened nipstick shaped/blanched white after nursing? ☐ Yes ☐ No
If yes, where? ☐ Right Side ☐ Left Side ☐ Both

Are your nipples becoming cracked, bruised or blistered after nursing? ☐ Yes ☐ No If yes, where? ☐ Right Side ☐ Left Side ☐ Both

Are your nipples bleeding? ☐ Yes ☐ No If yes, where? ☐ Right Side ☐ Left Side ☐ Both

Is there any severe pain when your infant attempts to latch? ☐ Yes ☐ No If yes, where? ☐ Right Side ☐ Left Side ☐ Both

Are you experiencing poor or incomplete breast drainage? ☐ Yes ☐ No

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Mother's Symptoms, Cont'd

Do you have a history of, or currently have, mastitis? ☐ Yes ☐ No

Do you have a history of, or currently have, nipple/infant oral thrush? ☐ Yes ☐ No

In a sentence or two, please share your current breastfeeding concerns: ____________________

In a sentence or two, please share your breastfeeding goals: ____________________

Baby's Symptoms/Habits

	Yes	Sometimes	No
Does your infant fall asleep while attempting to nurse?	☐	☐	☐
Does your infant slide off breast when latching/feeding?	☐	☐	☐
Does his/her upper lip curt inward (does not flip out) when latched?	☐	☐	☐
Does your infant have his/her mouth open at rest?	☐	☐	☐
Does milk or formula leak/spill out of mouth while feeding at breast/bottle?	☐	☐	☐
Is your infant experiencing colic symptoms?	☐	☐	☐
Does your infant become visibly frustrated at the breast?	☐	☐	☐
Does your infant exhibit reflux symptoms?	☐	☐	☐
Has your infant been diagnosed with reflux by a pediatrician?	☐	☐	☐
Is your infant extremely gassy?	☐	☐	☐
Has your doctor noticed slow or poor weight gain?	☐	☐	☐
Have you done any pre- and post- feeding weight checks? If so, what was the transfer rate?__________ ounces per___________ minutes	☐	☐	☐
Does your infant display gumming or chewing of your nipple while nursing?	☐	☐	☐
Is there a noticeable "clicking noise' while feeding?	☐	☐	☐
If yes, is it frequent?	☐	☐	☐
Does your infant seem satisfied/content after nursing sessions? If no, please explain:____________________	☐	☐	☐

What is the average length of feeding time at breast in minutes? ☐ Less than 15 ☐ 15-30 ☐ 30-45 ☐ 45-60 ☐ 60+

Additional Information to Note

____

Signature

☐ 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

____________________ Date

____________________ Parent/Guardian Printed Name

____________________ Patient Printed Name

Patient/Guardian Initials: __________