CHRISTINE L. KENYON
MA, IBCLC, RLC

LACTATION INTAKE FORM
(PART I)

Christine L. Kenyon, MA, IBCLC

Name:_____ Age:_____ Occupation:_____

Husband or partner's name:_____ Age:_____ Occupation:_____

Baby's name:_____ Male or female:_____

Date of birth:_____ Birth weight:_____ Gestational age:_____

Hospital:_____ Is this your first baby?_____

If you have more than one child, please list ages of other children:_____

Your address with zip code:_____

Email:_____

Phone number (home):_____ Cell:_____

Referred by:_____

Name of Pediatrician:_____ Phone:_____

Name of Obstetrician:_____ Phone:_____

Please read the following carefully and sign below: (Please make a copy for your records)

1. I understand that the lactation consultation will include assessment of the mother's breasts, the baby's suck, and observation of a feeding.
2. I understand that all medical care is to be provided only by my own and/or baby's health care provider (s). I consent for information about this consultation to be transmitted to my and/or baby's healthcare provider(s).
3. I understand that I will be charged a fee of $295.00 for this initial in-home consultation and that payment is due at the time of service. Check, Cash, or Venmo accepted.
4. I understand that included in this consultation, I have unlimited access of support through telephone and email for a period of 2 weeks after this initial consultation. Any additional telephone consultations after this period will be charged a small fee. In-home follow-up consultations are also available for a fee of $175.00.

Signature:_____ **Date:**_____

CHRISTINE L. KENYON
MA, IBCLC, RLC

LACTATION INTAKE FORM
(PART II)

Christine L. Kenyon, MA, IBCLC

What type of birth experience did you have? ❒ Vaginal Birth ❒ C-Section
Please describe your birth experience. If you've had a C-Section, please explain why?

_____

_____

Was there trauma to your or baby? ❒ Yes ❒ No
If there was trauma, please explain:

_____

_____

If yes to any of the following, please explain:

❍ Difficulty getting pregnant _____
❍ Infertility treatments _____
❍ Loss of previous pregnancy _____
❍ Depression _____
❍ Allergies _____
❍ Breast surgeries _____
❍ Eating disorders _____

Any medical conditions in you or your family? ❒ Yes ❒ No
If yes, please explain:

_____

Are you or baby taking medications? ❒ Yes ❒ No
If yes, please list medications:_____

Are you taking vitamins/supplements? ❒ Yes ❒ No
If yes, please list supplements:_____

Have you seen a lactation consultant after being discharged? ❒ Yes ❒ No
If yes, with whom:_____

Have you taken a breastfeeding class? ❒ Yes ❒ No
If yes, where:_____

Please briefly describe your concerns today:_____

_____

I agree that these statements are true to my knowledge and that this information will only be used to help Christine better understand your current needs.

Signature:_____ **Date:**_____