CLIENT INTAKE FORM

Client Information

Full Name	
Date of Birth	
Phone Number	
Email	
Address	
Emergency Contact Name	
Relationship	
Phone	

Infant/Childs Information

Full Name	
Date of Birth	
Gender	
Birth Weight	
Current Weight (if known)	
Gestational Age at Birth	
Birth	☐ Vaginal ☐ Cesarean ☐ Assisted (forceps/vacuum)
Was NICU care required	☐ Yes ☐ No
Any medical concerns or diagnosis for baby/infant	

Notes or Goals

Please share anything else you'd like me to be aware of before the consultation or any specific goals you have for our time together:

Completing this section before your appointment may help me better understand your journey so far, but please know there's absolutely no pressure to do so. I'll always make sure we spend enough time focusing on what matters most to you.

Feeding History and Current Concerns

Have you breastfed before? ☐ Yes ☐ No

If yes, briefly share any relevant experience:

What is your current feeding approach?

☐ Breastfeeding

☐ Expressing

☐ Donor milk

☐ Formula

☐ Other:

Are you currently experiencing any of the following?

☐ Pain during feeds

☐ Nipple damage

☐ Latching difficulties

☐ Low milk supply

☐ Abundant supply

☐ Blocked ducts / engorgement

☐ Mastitis

☐ Concern about baby's weight gain

☐ Expressing issues

☐ Other (please describe):

Postnatal Health & Wellbeing

Would you like support with any of the following: ☐ Emotional wellbeing ☐ Birth debrief

☐ Adjusting to parenthood ☐ Sleep and fatigue ☐ Relationships and support

Any other concerns since birthing?

OFFICE USE:

Date of Initial Consultation:
Initial Consultation: ☐ Antenatal ☐ Postnatal ☐ >6wks postnatal
Consent Form Signed: ☐ YES ☐ NO If no, reason:
Release of Information Form Signed: ☐ YES ☐ NO If no, reason:
Referral Required:
Referral Sent: