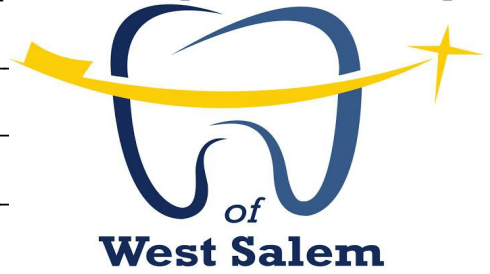


MOTHER / INFANT FOLLOW UP ASSESSMENT

Today's Date: _____

Family Dentistry



Patient's Name: _____ Birth Date: _____

Date of Procedure: _____ Tonque? _____ Lip? _____ Buccal Cheek Ties? _____

Birth Weight: _____ Weight at initial visit: _____ Weight today: _____

Have you noticed any improvements or changes since the procedure for your baby? Please check if improved.

- | | |
|---|--|
| <input type="checkbox"/> Deeper latch at breast or bottle | <input type="checkbox"/> Less gumming or chewing your nipple |
| <input type="checkbox"/> Less falling asleep while eating | <input type="checkbox"/> Pacifier stays in easier |
| <input type="checkbox"/> Slides or pops on and off the nipple less | <input type="checkbox"/> Milk dribbles out of mouth less |
| <input type="checkbox"/> Less colic symptoms / crying | <input type="checkbox"/> Sleeping longer |
| <input type="checkbox"/> Less reflux | <input type="checkbox"/> Less snoring or mouth breathing |
| <input type="checkbox"/> Less clicking or smacking noises | <input type="checkbox"/> Less moving around in sleep |
| <input type="checkbox"/> Less spit up OR <input type="checkbox"/> More spit up | <input type="checkbox"/> Nose congested less often |
| <input type="checkbox"/> Less gagging, choking, coughing when eating | <input type="checkbox"/> Baby is less frustrated at the breast or bottle |
| <input type="checkbox"/> Less gassy | How long does baby take to eat? _____ |
| <input type="checkbox"/> Better weight gain | How often does baby eat? _____ |
| <input type="checkbox"/> Less hiccups | |
| <input type="checkbox"/> Lip doesn't curl under anymore | |

Has anything worsened? If so, explain: _____

Have you noticed any changes in your symptoms since the procedure? If bottle-feeding: _____ N/A

- | | |
|--|--|
| <input type="checkbox"/> Less creased, flattened or blanched nipples | <input type="checkbox"/> Improved breast drainage |
| <input type="checkbox"/> Less lipstick shaped nipples | <input type="checkbox"/> Less infected nipples or breasts |
| <input type="checkbox"/> Less blistered or cut nipples | <input type="checkbox"/> Less plugged duct / engorgement / mastitis |
| <input type="checkbox"/> Less bleeding nipples | <input type="checkbox"/> Less nipple thrush |
| <input type="checkbox"/> Somewhat less pain <input type="checkbox"/> Significantly less pain | <input type="checkbox"/> Less using a nipple shield |
| | <input type="checkbox"/> Baby doesn't prefer one side over the other |

Pain before procedure (scale of 1-10): _____

Pain now (scale of 1-10): _____

Were you able to stretch the site 8X per day? How did it go? _____

How was your experience at our office? _____

Have you taken you child to see any of the following?

Chiropractor / If so, who and how often? _____

Lactation / If so, who and how often? _____

Massage or Occupational Therapy / If so, who and how often? _____