MOTHER / INFANT FOLLOW UP ASSESSMENT Today's Date:_____

Family Dentistry of West Salem

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.

___Deeper latch at breast or bottle
___Less falling asleep while eating
___Slides or pops on and off the nipple less
___Less colic symptoms / crying
___Less reflux
___Less clicking or smacking noises
___Less spit up **OR** ___ More spit up
___Less gagging, choking, coughing when eating
___Less gassy
___Better weight gain
___Less hiccups
___Lip doesn't curl under anymore

___Less gumming or chewing your nipple
___Pacifier stays in easier
___Milk dribbles out of mouth less
___Sleeping longer
___Less snoring or mouth breathing
___Less moving around in sleep
___Nose congested less often
___Baby is less frustrated at the breast or bottle
How long does baby take to eat?_____
How often does baby eat?_____

Has anything worsened? If so, explain:_____
_____

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

___Less creased, flattened or blanched nipples
___Less lipstick shaped nipples
___Less blistered or cut nipples
___Less bleeding nipples
___Somewhat less pain ____Significantly less pain

___Improved breast drainage
___Less infected nipples or breasts
___Less plugged duct / engorgement / mastitis
___Less nipple thrush
___Less using a nipple shield
___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? _____