PAIN AND SLEEP
Therapy Center

INFANT HEALTH QUESTIONNAIRE (IHQ)

PATIENT DEMOGRAPHICS

First Name:_____ Middle Initial:_____ Last Name:_____
Date of Birth: _____ Age(in Days or Weeks):_____
Gender: _____ SSN: _____
Address:_____
City: _____ State:_____ Zip Code:_____

PARENT/CAREGIVER CONTACT INFORMATION

Parent/Guardian Full Name: _____ Relationship to Patient: _____
Parent/Guardian Full Name: _____ Relationship to Patient: _____
Preferred Contact Number (for Dr. Green's follow-ups):_____
Email: _____
Occupation: _____
Employer Name: _____

PRIMARY CARE/OTHER PROVIDER INFORMATION

Pediatrician's Office: _____
Pediatrician's Name: _____
Lactation Consultant/IBCLC: _____
Bodyworker/Chiropractor:_____
Speech Language Pathologist:_____
Referred by: _____

Reason(s) for appointment:

Lip Tie Tongue Tie Consult Only

MEDICAL HISTORY

Please include surgeries, illness, or hospitalizations (ex. NICU stay, Jaundice)

Treatment	Doctor/Provider	Date of Treatment

If male, is he circumcised? ☐ YES or ☐ NO
If yes, any complications noted at procedure?_____

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PREGNANCY/BIRTH HISTORY:

If your child was adopted, please answer the following questions to the best of your knowledge.

# of weeks gestation at birth:_____ Birth Weight:___lb.___ oz

Did your child pass the newborn hearing screening: YES or NO

Frequent ear infections: YES or NO PE tubes: YES or NO

Please describe any health problems that the mother or infant experienced during pregnancy or following birth:_____

_____

Did the child stay in the NICU? ☐ YES or NO ☐ If yes, why:_____

_____

During The Birth Process did you experience any of the following:

Natural (no medications)		Challenging or Prolonged birth	
Vaginal		Forceps or Vacuum used at birth	
C-section		Pitocin used to induce labor	
Baby was breeched (Feet First)		C-Section was planned due to emergency	
C-Section was planned for convenience		C-Section was planned for repeat because mother had on prior	
C-Section was planned due to concerns about mother delivering vaginally		C-Section was planned due to failure to progress) baby wasn't coming down birth canal)	

CURRENT MEDICATIONS/VITAMINS

Please include all current prescriptions, over-the-counter, vitamins, herbs, etc.

Medication	Dosage	Reason for Taking

Was a Vitamin K shot given at birth: ☐ *YES or* ☐ *NO*

Baby's Medical Symptoms (Please indicate if there is any history of the following):

Cleft Lip/Palate		Heart Defect	
Family hx of bleeding disorders		Bleeding hx with baby	
Hernia		Family hx of keloids or aggressive healing/scarring	

How is your baby fed?

Breast		Bottle (Formula or Breast Milk)	
Breast and Bottle (Formula or Breast Milk)		Donated Breast Milk	
Syringe Feed		Feeding Tube	

Please describe your regiment: _____

_____

_____

FEEDING HISTORY

Baby's Feeding Symptoms (Please check all that apply):

Poor quality latch		Falls asleep prematurely while nursing	
Long/Short Feedings		Slides off breast	
Clicking while nursing		Reflux	
Gumming/Chewing/Clamping		Pacifier Problems	
Poor weight gain		Lip blister or callus	
Gassy		Torticollis	
Hiccups		Leaking from corners of mouth	
Prefers one side over the other		Using nipple shield	
Upper or Lower lip curling in (not flaring)		Recessed chin	
Congestion		Snorting/Noisy	

Weighted feed with lactation? How much was transferred in how much time? _____

Please elaborate on any specific feeding symptoms listed above. _____

_____

_____

_____

_____

Mother's symptoms (please check all that apply):

Pain or nipple damage		Rate 1-10: 1 being no pain 10 being severe pain	
Poor/Incomplete Drainage		Infected Nipples	
Vasospasm		Mastitis/Thrush	
Low Milk Supply		High Milk Supply	

ADDITIONAL INFORMATION

Is there anything else you would like us to know?

_____

_____

_____

_____

_____

_____

SIGNATURE

Patient Name:_____

*Parent/Guardian Signature:*_____

Date: _____

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DOCTORS USE ONLY

Lip classification(Stanford):I___II ____III ____ Evaluation: _____

Tongue classification(Coryllos):I___II ____III ____
Evaluation:_____

Treatment:_____
_____
_____
_____

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