MOTHER / INFANT FOLLOW-UP ASSESSMENT

Infant's Name _____Birth date _____ Today's Date _____

Date of Procedure _____ Tongue? ____ Lip? ____ Buccal Cheek Ties? _____

Birth Weight _____ Weight at initial visit _____ Weight today _____ Change _____

Have you noticed any 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 nippleless
___ Less colic symptoms/crying
___ Less reflux
___ Less clicking or smacking noises
___ Less spit up / ____ More spit up
___ Less gagging, choking, and coughing when eating
___ Less gassy / Less fussy
___ Less constipation / regular stools now
___ Better weight gain
___ Happier baby than before
___ Less hiccups

____ Lips flip out better / not curling under as much
____ Less gumming or chewing the nipple
____ Pacifier stays in better
____ Milk dribbles/leaks out of mouth less
____ Sleeping longer
____ Less snoring or mouth breathing
____ Less moving around in sleep
____ Nose congested less often
____ Baby babbles more or ___ makes new sounds
____ Baby is less frustrated at the breast or bottle
____ Eats solid foods better (if applicable)
How long does your baby take to eat? _____
How often does your 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
Pain before procedure (scale of 1-10) _____
Pain now (scale of 1-10) _____
___ Better emotional state / more confident

___ Improved breast drainage (baby gets more)
___ Less infected nipples or breasts
___ Less plugged ducts/engorgement/mastitis
___ Less nipple thrush
___ Less using a nipple shield
___ Baby doesn't prefer one side over other
___ Better milk supply

How are you doing mentally/emotionally? _____

Were you able to stretch the sites 4x a day? _____ Any issues? _____

How was your experience at our office? _____

Any other comments? _____

Thank you!

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