Client Info

Date:_____

Mother's Name: _____ DOB:_____

Addresss:_____

Phone:_____ Email:_____

Preferred method of communication: Call cell / Text/ Email

OB/Midwife: _____Practice:_____

Phone: _____ Fax: _____

Baby's Name: _____ ☐ Male ☐ Female

Baby's DOB: _____ If prenatal, EDD: _____

Infant's Primary Care Provider:_____

Practice:_____ Location:_____

Phone:_____ Fax:_____

Consent to Care Agreement:

* I understand that I am consenting to receive breastfeeding support services by an IBCLC (International Board Certified Lactation Consultant) and/ or a LEAARC certified breastfeeding educator and counselor.
* I understand that in order to properly support me and provide assistance with breastfeeding, a visit with the consultant may include:
    - A health history for me and my baby
    - A physical assessment of my breasts
    - An observation and assessment of how my baby breastfeeds
        - This may include a physical examination of my baby's oral function
    - Demonstrations of proper latch, positioning, and how to use breastfeeding tools and supplies
    - Sharing resources that are relevant to my needs and goals
    - Composing an individualized care plan for me and my baby
* I understand that any necessary medical care needed for me and my baby is to be provided by a primary care provider, not the lactation consultant or counselor.
* I waive, release and will never hold the lactation consultant or counselor responsible for any injuries, damages, losses or claims, either known or unknown. that may arise from any service provided. I understand that I am personally responsible for following my care plan.

By signing below I acknowledge that I have read and understand the statements above and am giving my consent to care:

Client's Signature:_____ **Date:**_____

Provider's Signature:_____ **Date:**_____

Health History

Does your health history include any of the following?

Bliss Lactation

Bliss Lactation, LLC
blisslactation@gmail.com
Chelsea DeSorbo, CLEC & Abby Case, CLEC
(503) 593-9432 (303) 594-8896

☐Allergies/Asthma ☐Anemia ☐Diabetes

☐High Blood Pressure ☐PCOS ☐Cancer

☐Thyroid Disorders ☐Heart Disease ☐Pregnancy loss

☐Eating Disorders ☐Liver Disease ☐Anxiety Disorder

☐Weight Loss Surgery ☐Kidney Disease ☐Depression

☐Hemorrhoids ☐GI issues/disorders ☐ Skin issues: Psoriasis, Eczema, etc

☐Sexually transmitted diseases: _____

☐Other:

_____

Have you had any of the following breast related surgeries/procedures?

☐Breast reduction when?_____

☐Breast implants when?_____ why?_____

☐Biopsy side:_____ when?_____ results?_____

☐Any other surgeries in the chest/thoracic

area:_____

Have you ever had or do you currently have any nipple piercings? ☐Yes ☐No

Please list any/all current medications and supplements:

_____

_____

_____

Do you currently:

☐Smoke tobacco how often?	☐Drink alcohol	☐Use cannabis	☐Other recreational drugs
_____	_____	_____	_____

1st pregnancy? ☐Yes ☐No

If no, how many other children?_____

Previous breastfeeding experience? ☐Yes ☐No How long?_____

Difficulty getting pregnant? ☐Yes ☐No

Fertility treatments or medications used:_____

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