Information for Currently Breastfed Infants

This section helps us understand possible influences from your child's mother's diet and lifestyle.

Current maternal supplements (include brand if known):

Current maternal medications (prescription or over-the-counter):

Current diet pattern (e.g. specialty diets, typical meals)

Known Food Intolerances or Allergies:

Stress Level (scale of 1–10): _____ (Where 1 is the lowest and 10 is the highest)

Quality of Sleep:
☐ 7–8 hours uninterrupted
☐ Wakes with baby frequently
☐ Insomnia even when baby sleeps

Describe: _____

Do you experience any pain while breastfeeding? ☐ Yes ☐ No

If yes, please describe: _____

Does your child experience frustration or distress while breastfeeding? ☐ Yes ☐ No

If yes, please describe: _____

Do you notice changes in your baby after you eat certain foods? ☐ Yes ☐ No

If yes, what foods? _____

Digestive issues in mom (bloating, constipation, etc.) ☐ Yes ☐ No

If yes, please describe: _____