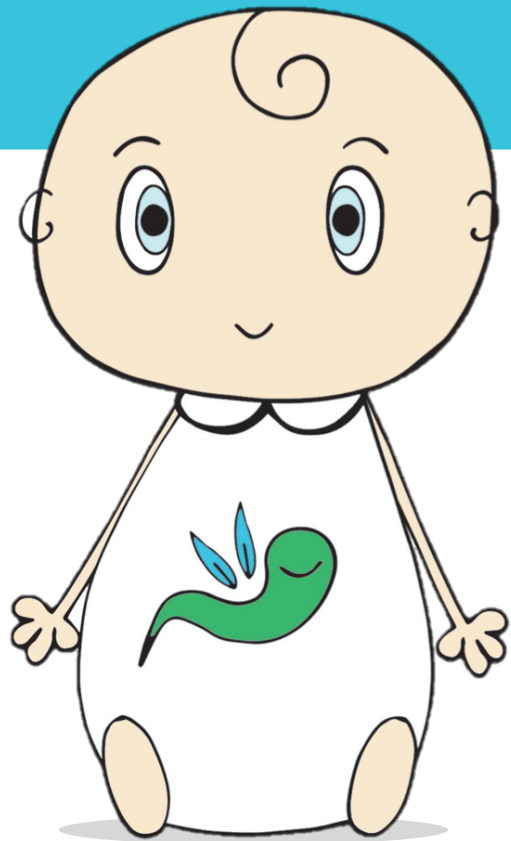
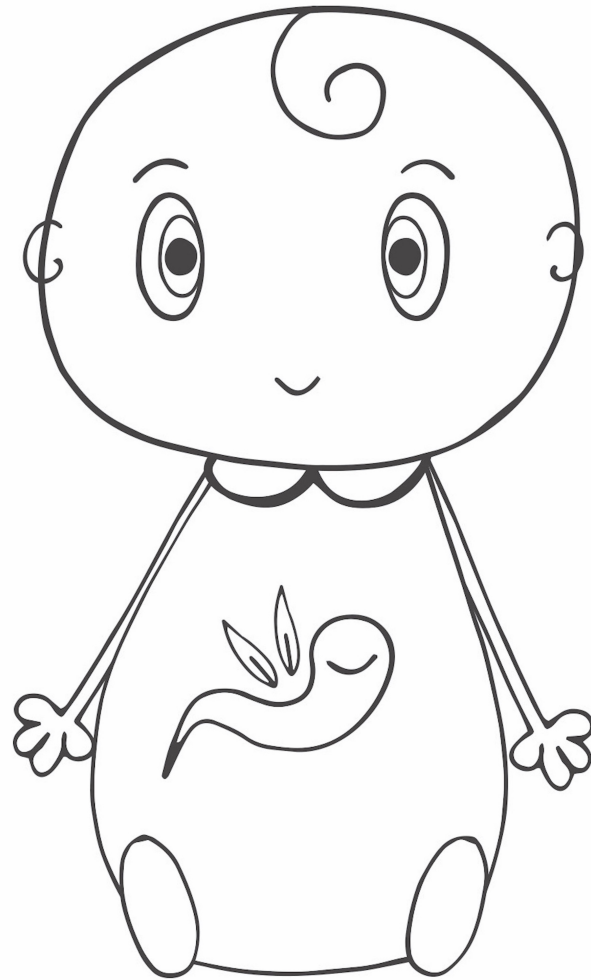


THE BABY REFLUX LADY'S

SYMPTOMS



This workbook accompanies the workshop on understanding the cause of your baby's discomfort



the baby reflux lady

Tick those symptoms on the left that your baby experiences now, before you start making changes
 On the right, rate out of 10, how severe these symptoms usually are for your baby, and circle whether they have these symptoms
 Always, Frequently or Rarely. Remember, these are your observations so your own definition of these terms is perfect.

Birth

	Yes	No
<input type="checkbox"/> Natural labour	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> No assistance at all	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Gentle assistance from midwife / consultant.....	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Forceps or Ventouse	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Induction	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Spontaneous rupture of membranes	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Cervical Sweep	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Manual rupture of membranes	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Caesarean Section (planned or emergency)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Extended labour	<input type="checkbox"/>	<input type="checkbox"/>

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Feeding

	Severity	Always	Frequently	Rarely
<input type="checkbox"/> Frequent feeds (more than 8 milk feeds / day under 6 months)	____/10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Short feeds	____/10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Falls asleep during a feed	____/10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Often refuses to feed	____/10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Pushes breast or bottle away	____/10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Turns head when trying to feed	____/10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Tugs at the breast during a feed	____/10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Milk spills from mouth during a feed	____/10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Milk comes back up through nose	____/10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Possetting (bringing up milk then swallowing it again	____/10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Splutters, coughs, gags or chokes during a feed	____/10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Gulps when feeding	____/10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Claws at face or breast when feeding	____/10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hits when feeding	____/10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bobs on and off the breast during a feed	____/10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Can hear milk sloshing in baby's tummy	____/10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Spits up frequently	____/10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Makes a clicking sound	____/10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Appears uncomfortable.....	____/10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Appears to be in pain	____/10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Symptoms After Feeding

	Severity	Always	Frequently	Rarely
<input type="checkbox"/> Projectile vomit	____/10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Frequent vomiting	____/10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Green or yellow vomiting	____/10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Vomit has blood in it	____/10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Chokes or blue spells	____/10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Brings up food after several hours	____/10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Squirms around or grunts	____/10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Respiratory Symptoms

	Severity	Always	Frequently	Rarely
<input type="checkbox"/> Coughing	____/10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Stuffy or Blocked nose	____/10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Runny nose	____/10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Difficulty breathing (ant time of the day or nigh	____/10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Face goes blue	____/10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Cold-like symptoms	____/10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sneezing	____/10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Wheezing	____/10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sleep apnoea (stops breathing during sleep)	____/10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Digestive Symptoms

	Severity	Always	Frequently	Rarely
<input type="checkbox"/> Acidic or smelly breath	____/10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Rumbly tummy	____/10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Rock hard tummy	____/10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Tender tummy	____/10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Swollen tummy or bloated abdomen	____/10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Diarrhea	____/10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Constipation	____/10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Mucous in poo	____/10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Blood in poo	____/10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Green poo	____/10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Black in poo (except after eating a banana)	____/10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Lots of wind	____/10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Painful wind or gas	____/10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hiccoughs	____/10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Positional

	Severity	Always	Frequently	Rarely
<input type="checkbox"/> Plagiocephaly / Flat spot on head	____/10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sleeps with head at extended angle	____/10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Only happy feeding on one side / position	____/10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Cannot open mouth very wide	____/10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> When mouth is wide open it looks off centre	____/10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Torticollis / twisting of head and neck	____/10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Cannot open mouth really wide or for long periods of time.....	____/10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Sleep Symptoms

	Severity	Always	Frequently	Rarely
<input type="checkbox"/> Frequent night waking (more than 2 / night from 8 weeks).....	____/10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sleep Apnea (stops breathing for a period)	____/10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Mostly sleeps in someone's arms or on shoulder	____/10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Difficult to get baby to sleep.....	____/10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Wakes soon after being put down	____/10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Difficulty staying asleep	____/10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Needs motion to sleep (car, bouncing, buggy)	____/10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>