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Birth Doula & Lactation Counseling Services

New Client Intake Form

GENERAL INFORMATION

Name _____

Partner's Name _____

Home Address _____

E-mail _____

Phone Number _____

Partner/Other Phone Number _____

Your Birth Date _____

EMERGENCY CONTACT

Emergency Contact Name _____

Phone Number _____

Relationship _____

HEALTH CARE PROVIDER INFORMATION

Name _____

Type of Provider: Midwife Doctor Other (please specify)

Address _____

Phone Number _____

71 Berkeley Drive, Tenafly, NJ 07670 • 201.245.7614 • stephanie@bergendoula.com
website: https://www.bergendoula.com Facebook: https://www.facebook.com/bergendoula
emotional support and physical comfort when women need women most

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Location where you plan to deliver? Home Hospital Birth Center Other

Name and address of delivery location/backup hospital if you plan to deliver at a birth center or at home

_____

Do you have health insurance? _____

GENERAL HEALTH INFORMATION

Do you have allergies? (if yes, please list) _____

Have you had any recent illnesses, surgeries, injuries. accidents or trauma ? (if yes, please describe)

_____

Do you currently take any prescription or non-prescription medications (herbs, natural supplements, vitamins, over-the-counter)? If yes, please list what you take and what it's for

_____

_____

Do you currently have, or do you have a history of, any of the following medical conditions? (circle all that apply)

High blood pressure	Migraine headaches	HIV
Low blood pressure	Menstrual problems	Herpes
Type 1 Diabetes	Uterine fibroids	HPV / Genital warts
Type 2 Diabetes	Scoliosis	Abnormal blood clotting
Asthma	Seizure disorder / epilepsy	Carpal tunnel syndrome
Anemia	Cancer	None of the above

Do you currently have, or do you have a history of any of the following psychological conditions? (circle all that apply)

Anxiety	Dissociative disorder	Bulimia
Depression	Personality disorder	Binge Eating
Bipolar disorder	Obsessive-Compulsive	Addictive behavior
Schizophrenia	Disorder	Chronic insomnia
Post-Traumatic Stress	Phobia(s)	None of the above
Disorder	Anorexia	

Other medical/psychological condition not listed above _____

Do you currently see a therapist or a counselor? _____

Explain anything else you would like me to know about your health condition _____
_____

PREVIOUS PREGNANCY INFORMATION

How many times have you given birth? (twins, triplets, etc count as 1 birth) _____

Out of previous pregnancies, how many were carried to term (37 weeks +)? _____

Out of previous pregnancies, how many were preterm (born 24 – 37 weeks)? _____

How many children do you have? Please list name(s) and age(s) _____
_____

Have you given birth to multiples (twins, triplets, etc)? _____

Which types of births have you experienced? (circle all that apply)

This will be my first birth
Vaginal
C-section
VBAC (vaginal birth after Cesarean)
Elective induction
Induction for medical reasons
Home birth
Hospital birth
Birth center birth
Water birth

How long did your previous labor(s) last? _____

Have you had any of the following pregnancy-related health conditions in PAST pregnancies? (circle all that apply)

Rh incompatibility
Pre-Eclampsia
Preterm Labor
Low Birth Weight
Macrosomia (large baby)
Polyhydramnios
Oligohydramnios
Group B Strep
Gestational Diabetes
Placenta Previa
Placental Abruption
Vena Cava Compression
Postpartum Hemorrhage
Postpartum Depression
Genetic Disorder

Intrauterine Growth Restriction (IUGR)
Hyperemesis Gravidarum (excessive vomiting)
Gestational Hypertension (high blood pressure during pregnancy)
None of the above

Please tell me anything you would like me to know about your past pregnancies

_____

_____

CURRENT PREGNANCY INFORMATION

Baby's Due Date _____

Are you expecting multiples (twins, triplets, etc)? _____

Gender of the Baby (circle the applicable answer) Girl Boy One of Each(twins) Don't know yet but plan to find out It will be a surprise!

Do you have a name picked out? If yes, you can share it with me here if you like

_____

Do you plan to share the name with others? Yes No We would like it to be a surprise for some people so please don't share!

Have you taken, or are you planning on taking, any childbirth education classes? If so, what classes and where will/did you attend them?

What type of birth are you hoping for? (circle the applicable answer) vaginal cesarean birth VBAC elective induction induction for medical reasons water

Do you plan to birth (circle the applicable answer): Naturally (comfort measures/no pain medication)? Epidural? Other pain medication?

Have you had any of the following pregnancy-related health conditions in your current pregnancy? (circle all that apply)

Rh incompatibility
Hyperemesis Gravidarum (excessive vomiting)
Gestational Hypertension (high blood pressure during pregnancy)
Pre-Eclampsia
Preterm Labor
Intrauterine Growth Restriction (IUGR)
Low Birth Weight
Macrosomia (large baby)
Polyhydramnios
Oligohydramnios
Group B Strep
Gestational Diabetes
Placenta Previa
Vena Cava Compression
Genetic Disorder
None of the above

Please list any conditions you have that are not listed above _____
_____

BIRTH WISHES

Do you have a birth plan/vision? Yes No Need help

(If you have a birth plan/vision already, feel free to attach a copy to this form.)

What are the 3 most important outcomes that you desire for this birth? _____
_____
_____

Please describe the role you envision for me at your birth _____
_____
_____

Who else will be with you at the birth, and what role would you like them to play?

Is there anyone that you do NOT want to be present at the birth, or during the immediate postpartum period?
_____

What would your partner like me to do to help them be more supportive to you during labor?
_____

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Do you have any religious or cultural beliefs that you would like me to be aware of?

_____

_____

Have you had any difficulties/complications/restrictions (physical, emotional, or other) with and during this pregnancy? _____

_____

_____

Do you have any fears about this birth? _____

_____

_____

What type of comfort measures do you think you would like to use during labor?

Distractions	Walking, Dancing, Swaying	Focal Points
Breathing Patterns	Water (tub/Shower)	Aromatherapy
Massage	Hot/Cold Therapy	Music
Birth Ball	Visualization/Imagery	

Other techniques you would like to use _____

_____

_____

Are you planning on breast feeding your baby? _____

Are there any particular topics that you would like to focus on during our prenatal visit(s)/conversations?

_____

_____

_____

Comments/questions about absolutely anything! _____

_____

_____

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