



Birth Doula & Lactation Counseling Services

## New Client Intake Form

### GENERAL INFORMATION

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Due Date \_\_\_\_\_

Home Address \_\_\_\_\_

E-mail \_\_\_\_\_ Phone Number \_\_\_\_\_

Partner's Name \_\_\_\_\_ Partner/Other Phone Number \_\_\_\_\_

### EMERGENCY CONTACT

Emergency Contact Name \_\_\_\_\_

Phone Number \_\_\_\_\_ Relationship \_\_\_\_\_

### HEALTH CARE PROVIDER INFORMATION

Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Type of Provider:    Midwife                      Doctor                      Other (please specify)

Address \_\_\_\_\_

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

Name and address of delivery location  
\_\_\_\_\_

Do you have health insurance? \_\_\_\_\_



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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)

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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

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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 Disorder | Addictive behavior |
| Schizophrenia                  | Disorder                      | Chronic insomnia   |
| Post-Traumatic Stress Disorder | Phobia(s)                     | None of the above  |
|                                | 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 \_\_\_\_\_

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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  
\_\_\_\_\_



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CURRENT PREGNANCY INFORMATION

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

Please list any conditions you have that are not listed above \_\_\_\_\_  
\_\_\_\_\_



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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?

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

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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?

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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  
Breathing Patterns  
Massage  
Birth Ball

Walking, Dancing, Swaying  
Water (tub/Shower)  
Hot/Cold Therapy  
Visualization/Imagery

Focal Points  
Aromatherapy  
Music



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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! \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

When finished please SAVE the New Client Intake form  
and email it to [stephanie@bergendoula.com](mailto:stephanie@bergendoula.com)