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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)

_____

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
- ☐ Low blood pressure
- ☐ Type 1 Diabetes
- ☐ Type 2 Diabetes
- ☐ Asthma
- ☐ Anemia
- ☐ Migraine headaches
- ☐ Menstrual problems
- ☐ Uterine fibroids
- ☑ Scoliosis
- ☐ Seizure disorder / epilepsy
- ☐ Cancer
- ☐ HIV
- ☐ Herpes
- ☐ HPV / Genital warts
- ☐ Abnormal blood clotting
- ☐ Carpal tunnel syndrome
- ☐ 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
- ☐ Depression
- ☐ Bipolar disorder
- ☐ Schizophrenia
- ☐ Post-Traumatic Stress Disorder
- ☐ Dissociative disorder
- ☐ Personality disorder
- ☐ Obsessive-Compulsive Disorder
- ☐ Phobia(s)
- ☐ Anorexia
- ☐ Bulimia
- ☐ Binge Eating
- ☐ Addictive behavior
- ☐ Chronic insomnia
- ☐ None of the above

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
- ☐ 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 (high level of amniotic fluid)
- ☐ 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 _____

_____

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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?

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?

_____

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
- ☐ 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

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