Amanda Matthews
Canyon Lake
CA, 92587

Birth Doula
INTAKE FORM

Congratulations on your pregnancy! I am honored to take this journey with you, and look forward to learning more about you and your desired birth experience. Please complete all fields below so that we may determine how I can serve you best.

Name (client) _____ Partner Name _____

Address _____ City, State _____ ZIP _____

Email _____ Phone _____

Partner Email _____ Partner Phone _____

Preferred Method of Contact: ◯ Email ◯ Text ◯ Call

What is thebest time to reach you? ◯ Morning ◯ Afternoon ◯ Evening

EMERGENCY CONTACT

Name _____ Phone _____

Relationship _____

CARE PROVIDER DETAILS

OBGYN/Midwife Name _____

Delivery Location: ◯ Home ◯ Birth Center ◯ Hospital ◯ Not Sure Yet

Delivery Location Name _____

Address _____ City, State _____ ZIP _____

Have you toured the delivery location? ◯ Yes ◯ No

Do you have health insurance? ◯ Yes ◯ No

Did you choose your care provider specifically? ◯ Yes ◯ No

Are you comfortable with your care provider? ◯ Yes ◯ No

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CURRENT PREGNANCY DETAILS

Estimated Due Date _____ If expecting multiples, how many? _____

Baby Gender: ◯ Boy ◯ Girl ◯ Don't Know Yet ◯ It's a Surprise!

Have you chosen a name? If so, feel free to share here (if you wish) _____

Will you be sharing baby's name with others? ◯ Yes ◯ No

Overall, how has your pregnancy been so far? Emotionally? Physically?

How much sleep have you been able to get each night? Do you have an opportunity to rest or nap each day?

Do you have any current pregnancy-related health conditions? Please check all that apply.

- ◯ Subchorionic Hematoma
- ◯ Hyperemesis Gravidarum
- ◯ Pre-Eclampsia
- ◯ Low Birth Weight
- ◯ Preterm Labor
- ◯ Gestational Hypertension
- ◯ Rh Incompatibility
- ◯ Intrauterine Growth Restriction
- ◯ Polyhydramnios
- ◯ Oligohydramnios
- ◯ Macrosomia
- ◯ Group B Strep
- ◯ Gestational Diabetes
- ◯ Vena Cava Compression
- ◯ Placenta Previa
- ◯ Genetic Disorder
- ◯ Pica
- ◯ None of the Above

Please list any pregnancy-related conditions not listed above.

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PAST PREGNANCY DETAILS

What number pregnancy is this for you? _____

Number of previous births: _____

Of your previous pregnancies, how many were carried to term? (37 weeks) _____

Of your previous pregnancies, how many were preterm (born 24-37 weeks) _____

Have you experienced any of the following types of births? Check all that apply

- ◯ This will be my first birth
- ◯ Vaginal
- ◯ Cesarean Section
- ◯ VBAC
- ◯ Elective Induction
- ◯ Induction for Medical Reasons
- ◯ Home Birth
- ◯ Hospital Birth
- ◯ Birth Center Birth
- ◯ Water Birth

How many children do you have? Please list their names and ages below:

How long was your previous labor? _____

Have you had any of the following pregnancy-related health conditions in the past? Check all that apply.

- ◯ Subchorionic Hematoma
- ◯ Hyperemesis Gravidarum
- ◯ Pre-Eclampsia
- ◯ Low Birth Weight
- ◯ Preterm Labor
- ◯ Gestational Hypertension
- ◯ Rh Incompatibility
- ◯ Intrauterine Growth Restriction
- ◯ Polyhydramnios
- ◯ Oligohydramnios
- ◯ Macrosomia
- ◯ Group B Strep
- ◯ Gestational Diabetes
- ◯ Vena Cava Compression
- ◯ Placenta Previa
- ◯ Genetic Disorder
- ◯ Pica
- ◯ None of the Above

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MEDICAL HISTORY

Do you have any allergies (food, medication, etc.) or food preferences?

Have you had any recent illnesses, surgeries, injuries. accidents or trauma ?

Have you ever had any procedures done that might affect your birth experience?

Are you taking any prescription or non-prescription medications? If yes, please list your medications below and what they are for.

Do you currently have, or have ever had, any of the following medical conditions? Check all that apply.

- ◯ Anemia
- ◯ Asthma
- ◯ Menstrual Problems
- ◯ High Blood Pressure
- ◯ Low Blod Pressure
- ◯ Uterine Fibroids
- ◯ Type 1 Diabetes
- ◯ Type 2 Diabetes
- ◯ Abnormal Blood Clotting
- ◯ Scoliosis
- ◯ Migraine Headaches
- ◯ Epilepsy
- ◯ HIV
- ◯ Cancer
- ◯ Herpes
- ◯ HPV
- ◯ Carpal Tunnel Syndrome
- ◯ None of the Above

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Do you have any psychological or emotional conditions?

BIRTH PREPARATION

Have you taken, or do you plan on taking, any childbirth education classes? If yes, please share class details below.

Are you and your partner reading any pregnancy/childbirth/postpartum/breastfeeding books? If yes, please share the titles below.

Are you doing any activities to prepare for birth, emotionally and/or physically?

Are there any topics you would like to discuss further? Check all that apply.

- ◯ Ways Labor Can Begin
- ◯ Early Labor Signs and Signals
- ◯ Stages of Labor
- ◯ Timing and Contractions
- ◯ Natural Comfort Strategies
- ◯ Labor Positions
- ◯ Unmedicated Childbirth
- ◯ Unmedicated Induction
- ◯ Pain Medications
- ◯ Common Labor Procedures
- ◯ Episiotomy
- ◯ Assisted Vaginal Delivery
- ◯ Cesarean Section
- ◯ Postpartum Support Plan
- ◯ Postpartum Mood Disorder

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BIRTH PLAN

What is your birth vision? If all could go perfectly, what would that look like for you?

Do you have a birth plan? (If not, we can create one together.) _____

Have you shared your birth preferences with your provider? _____

Does your provider know a doula will be present at birth? _____

During early labor, when does your provider want to be contacted? _____

Have you discussed protocols with your provider if you go past your estimated due date?

_____

Please describe the role you envision for your partner at your birth. Hands on, share doula support, etc.

In addition to your partner, will there be anyone else at your birth? If yes, how do you envision their role?

Is there anyone that you would not like present at your birth, or immediately following birth? Please list their names below.

_____

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Do you have any fears or concerns regarding this birth?

Are there any religious or cultural beliefs I should be aware of regarding your birth?

Do you have any preferences for early labor? Check all that apply.

- ◯ Continuous Fetal Monitoring
- ◯ Intermittent Fetal Monitoring
- ◯ No IV or Heparing Lock
- ◯ IV
- ◯ Limited Vaginal Checks
- ◯ Vaginal Checks per Staff Protocol
- ◯ Sponataneous Mebrane Rupture
- ◯ Medications Offered
- ◯ Medications Not Offered
- ◯ Epidural

Are there any non-medical comfort measures that you would like to explore? Check all that apply

- ◯ Massage
- ◯ Music Therapy
- ◯ Aromatherapy
- ◯ Acupressure Points
- ◯ Dancing/Swaying
- ◯ Directed Breathing
- ◯ Visualization
- ◯ Rebozo
- ◯ Herbal Support
- ◯ Hot/Cold Therapy
- ◯ Birth Ball
- ◯ Hydrotherapy (water)

In previously painful or emotionally intense situations, what has been comforting?

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Overall, how do you envision a doula's support being most helpful to you?

Do you have any additional general labor/birth preferences? Check all that apply.

- ◯ Perineal Massage
- ◯ Episiotomy
- ◯ Tear Over Episiotomy
- ◯ Pictures
- ◯ Place Baby on Mom's Chest Immediately
- ◯ Delayed Cord Cutting
- ◯ Partner Cut Cord
- ◯ Care Provider Cut Cord
- ◯ Video
- ◯ Clean Baby Before Placing on Mom's Chest
- ◯ Partner Catch Baby
- ◯ Announce Sex of Baby
- ◯ Pictures
- ◯ Save Placenta
- ◯ Delay Newborn Procedures for 1 hour

POSTPARTUM CARE

Preferred feeding method: ◯ Breastfeeding ◯ Formula ◯ Combination ◯ Not Sure Yet

Do you have any experience with nursing? If yes, tell me about it.

Do you have any concerns about your ability to feed your baby?

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During the initial postpartum period, would you like your care provider to:

- ◯ Give Pacifier
- ◯ Bottle Feed
- ◯ Waive Eye Ointment
- ◯ Waive Vitamin K Shot
- ◯ Waive Glucose Test
- ◯ Waive PKU Test
- ◯ Waive Hepatitis B Vaccine
- ◯ Circumcision (w/anesthesia)

Do you have any postpartum concerns?

What kind of postpartum support will you have?

Would you like any additional information on the following? Check all that apply

- ◯ Perineum Care
- ◯ C-Section Recovery
- ◯ Postpartum Expectations
- ◯ Nursing
- ◯ Breast Pumps
- ◯ Postpartum Depression
- ◯ Diet
- ◯ Car Seat Installation
- ◯ Baby Wearing

Do you have any questions or anything else you would like to share with me?