PRECIOUS MOMENT DOULA

Intake Form

GENERAL INFORMATION

Client's Name: _____

Email Address: _____ Phone Number: _____/_____/_____

Address: _____

City: _____ State: _____ Zip: _____

Status: __ Single __ Married __ Divorced __ Other Date of Birth: _____/_____/_____

Partner's Name: _____

Email Address: _____ Phone Number: _____/_____/_____

EMERGENCY CONTACT

Contact's Name: _____ Phone Number: _____/_____/_____

Relationship: _____ Cell Number: _____/_____/_____

HEALTHCARE PROVIDER INFORMATION

Name: _____

Provider Type: ___ Midwife ____ Doctor ___ Other Phone Number: _____/_____/_____

Address: _____

City: _____ State: _____ Zip: _____

The location where you plan to deliver? ____ Home ____Hospital ____ Birth Center ___ Other

The delivery location's name and address _____

_____

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GENERAL HEALTH INFORMATION

Any known allergies (If yes, please list):_____

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

Do you actively use any prescription or over-the-counter drugs, herbal products, dietary supplements, or over-the-counter vitamins? 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? (check 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? (Check 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 conditions 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 preterm (born 24 – 37 weeks)? _____

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

_____

Have you expierenced pregnancy or child loss? If so what gestation or age? _____

_____

Which types of births have you experienced? (check 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? (check 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

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CURRENT PREGNANCY INFORMATION

Baby's Due Date: _____ Are you expecting multiples? _____

Gender of the Baby (check the applicable answer):

____ Girl ____ Boy ____ One of Each (twins) ___ Don't know yet ____ 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 ____ It will be a Surprise

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? _____vaginal _____ cesarean birth _____VBAC

_____elective induction _____ induction for medical reasons _____ water

Do you plan to birth: ____ 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? (check 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
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- ☐ Group B Strep
- ☐ Gestational Diabetes
- ☐ Placenta Previa
- ☐ Vena Cava Compression
- ☐ Genetic Disorder
- ☐ None of the above

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BIRTH PREFERENCES

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

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 of 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? _____

_____

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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

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!

_____

_____

_____

_____

_____

_____

_____

_____