CLIENT INFO SHEET

FULL NAME: ______________________________ **DOB:** ______________ **AGE:** ________

MAIDEN NAME: ______________________________ **SSN:** ______________ **SEX:** ________

ETHNICITY: ______________ **RELIGION:** ______________ **PRIMARY LANGUAGE:** ______________

EMAIL: ____

PHONE #: ______________________________ **ALT PHONE #:** ______________________________

ADDRESS: ____

____

OCCUPATION: ______________________________ **WORK #:** ______________________________

HIGHEST LEVEL OF EDUCATION: ______________ **PLACE OF BIRTH:** ______________________________

RELATIONSHIP STATUS:

- ☐ Legally Married/Living w/ Partner
- ☐ Divorced/Separated/Widowed
- ☐ Single/Living w/ Partner
- ☐ Single/NOT Living w/ Partner

EMERGENCY CONTACT:

NAME: ______________________________

PHONE: ______________________________

PARTNER INFORMATION

FULL NAME: ______________________________ **DOB:** ______________ **AGE:** ________

MAIDEN NAME: ______________________________ **SSN:** ______________ **SEX:** ________

ETHNICITY: ______________ **RELIGION:** ______________ **PRIMARY LANGUAGE:** ______________

EMAIL: ____

PHONE #: ______________________________ **ALT PHONE #:** ______________________________

OCCUPATION: ______________________________ **WORK #:** ______________________________

HIGHEST LEVEL OF EDUCATION: ______________ **PLACE OF BIRTH:** ______________________________

MEDICAL INSURANCE

- ☐ YES (please bring your insurance card to first visit)
- ☐ NO

BIRTH TEAM:

Primary MW: ______________________________

Backup MW: ______________________________

Student/Assist: ______________________________

CLIENT: ______________________________ DOB: ____________________

HEALTH HISTORY

PREGNANCY DATING

FIRST Day of Last Menstrual Period: ____________________ **SURE / UNSURE** Was it normal? **YES / NO**

Date of Pg. Test: ____________________ Conception Date: ____________________ **SURE / UNSURE**

Planned Pregnancy? **YES / NO**

METHOD OF CONCEPTION

- ☐ INTERCOURSE
- ☐ IVF
- ☐ IUI
- ☐ SURROGACY
- ☐ OTHER ______________________________

RECENT BIRTH CONTROL

- ☐ NFP
- ☐ CONDOMS/BARRIER
- ☐ IUD
- ☐ NUVARING OR PATCH
- ☐ THE PILL
- ☐ OTHER ________________________

MENSTRUAL HISTORY/SEXUAL HISTORY

Age Menstruation Began ________ Days Between Cycles __________ Length of Cycles __________ Periods Regular? **YES / NO**

Age Sexual Activity Began ________ # of Sexual Partners __________

Date of Last PAP ______________ Normal? **YES / NO** History of Abnormal PAP? **YES / NO** Date ______________

HISTORY OF SEXUALLY TRANSMITTED INFECTIONS OR RELATED CONDITIONS

- ☐ Bacterial Vaginosis
- ☐ Chlamydia
- ☐ Gonorrhea
- ☐ Yeast
- ☐ Hepatitis
- ☐ Herpes, Genital
- ☐ HIV
- ☐ Human Papillomavirus (HPV)
- ☐ Pelvic Inflammatory Disease (PID)
- ☐ Pubic Lice
- ☐ Syphilis
- ☐ Trichomoniasis
- ☐ Other ____________________

- ☐ Endometriosis
- ☐ Uterine or Cervical Issues
- ☐ Uterine Biopsy
- ☐ Cervical Biopsy
- ☐ Non-Cancerous Breast Conditions
- ☐ PCOS, Ovarian Cysts, Abnormal Periods
- ☐ Candidiasis (Yeast)
- ☐ Other ______________

OBSTETRICAL HISTORY/PREVIOUS PREGNANCIES

TOTAL PREGNANCIES ____ FULL TERM BIRTHS ____ PREMATURE ____ MISCARRIAGE ____ ABORTION ____ ECTOPIC ____

LIVE BIRTHS ____ STILL BIRTHS ____ LIVING CHILDREN ____ CESAREAN BIRTHS ____ VAGINAL BIRTHS AFTER CESAREAN ____

If Rh negative (blood type), did you receive Rhogam after any miscarriage or abortion, and after births of Rh+ babies? ☐ Yes ☐ No

CLIENT: ____ DOB: ________________________

PLEASE LIST INFORMATION ABOUT YOUR PREVIOUS BIRTHS (if you have had more than 5 pregnancies, please continue on back):

Pregnancy #	1	2	3	4	5
Child's Name					
Date of Birth or Loss (Month/Year)					
Gender					
Birth Weight					
Weeks Gestation at Delivery					
Live / Miscarriage / Abortion					
Complications of pregnancy					
Place of birth (Home, Hospital or Birth Center)					
Vaginal or Cesarean Birth					
If Cesarean Birth, Reason					
Was labor induced or Pitocin used					
1st sign of labor					
Length of Active Labor					
Length of Pushing					
Vacuum or Forceps					
Total Length of Labor					
Pain medication/s					
Episiotomy, tear/s or stitches					
Complications during labor and/or birth					
Complications or issues with newborn					
Birth Defects or inherited disorders					
Excessive bleeding					
Complications of postpartum period					
Postpartum Depression					

Are there any special circumstances, issues, or problems pertaining to previous pregnancies, labor and births, or the postpartum period that you would like to discuss?

____

____

____

Please tell us about any cultural, spiritual, religious, special preferences or expectations you have pertaining to your care:

____

____

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____

CLIENT: ______________________________ DOB: ____________________

GENERAL/SYSTEMIC CONDITIONS

- ☐ Anemia/Blood Disorder
- ☐ Autoimmune Disease ____________________
- ☐ Cancer ____________________
- ☐ Chronic Fatigue
- ☐ Chronic ENT Condition
- ☐ Respiratory/Lung Issues
- ☐ Asthma
- ☐ High Blood Pressure
- ☐ Heart Disease or Defect
- ☐ Varicose Veins/Blood Clots/Stroke
- ☐ Hemorrhage
- ☐ Blood Transfusion
- ☐ Hepatitis or Liver Disease
- ☐ Diabetes
- ☐ Thyroid Disorders
- ☐ Gastrointestinal Condition
- ☐ Kidney or Bladder Condition
- ☐ Frequent UTIs
- ☐ Back or Sacral Injury
- ☐ Aching Joints
- ☐ Season Allergies
- ☐ Eye/Vision Problems
- ☐ Ear/Hearing Problems
- ☐ Dental Problems
- ☐ Skin Issues
- ☐ Birth Defect/Congenital Malformation/Genetic Disorder
- ☐ Exposure to toxins work or home

NEUROLOGICAL/PSYCHOLOGICAL

- ☐ Depression (General)
- ☐ Anxiety (General)
- ☐ OCD
- ☐ Bipolar Disorder
- ☐ Hx of Postpartum Depression
- ☐ Hx of Postpartum Anxiety
- ☐ Other Psychiatric Illness ____________________
- ☐ Neurological Problem or Seizures
- ☐ Autism Spectrum Disorder
- ☐ Intellectual or Learning Disability
- ☐ Migraines/Chronic Headaches

SURGERIES

Please list the type of surgery, reason and date of procedure.

____
____
____
____
____

NUTRITION AND EXERCISE

- ☐ Worried about access to food
- ☐ Qualifies for a food assistance program (SNAP/WIC)
- ☐ Current or History of Eating Disorder
- ☐ Dietary restrictions or concerns
- ☐ Exercise restrictions or concerns

MIDWIFE NOTES

____
____
____
____
____

CLIENT: ____ DOB: ________________________

ALCOHOL & DRUGS

- ☐ **Alcohol Use**
  - ☐ Current (Frequency: ____)
  - ☐ Past (Frequency: ____)
  - ☐ Quit for Pregnancy
- ☐ **Tobacco or Nicotine Use**
  - ☐ Current (Frequency: ____)
  - ☐ Past (Frequency: ____)
  - ☐ Quit for Pregnancy
- ☐ **Marijuana/THC/CBD Use**
  - ☐ Current (Frequency: ____)
  - ☐ Past (Frequency: ____)
  - ☐ Quit for Pregnancy
- ☐ **Opiate Use and/or IV Drug Use**
  - ☐ Current (Frequency: ____)
  - ☐ Past (Frequency: ____)
  - ☐ Quit for Pregnancy
- ☐ Has participated in a treatment program
- ☐ Feels alcohol/drug use is problematic or worrisome to others

MEDICATIONS & SUPPLEMENTS

Please list all medications and supplements, dosages and reasons for taking.

CLIENT: ________________________________ DOB: ____________________

SOCIAL & SAFETY ASSESSMENT

Current Life Stress

- ☐ Financial Worries
- ☐ Worries about food
- ☐ Family Stress
- ☐ Legal Concerns
- ☐ Recent loss of loved one
- ☐ Worries about current pregnancy
- ☐ Problems with alcohol or drugs
- ☐ Work Problems
- ☐ Worries about shelter
- ☐ Worries about healthcare
- ☐ Worries about transportation

History of Trauma/Abuse & Current Safety

- ☐ **Abuse/Trauma as Child**
  - ☐ Emotional/Neglect
  - ☐ Physical/Neglect
  - ☐ Sexual/Coercion
- ☐ Unstable Housing
- ☐ Parent(s) Incarcerated
- ☐ Food Shortages
- ☐ Witnessed abuse of others

- ☐ **Abuse/Trauma as Adult**
  - ☐ Emotional/Neglect
  - ☐ Physical/Neglect
  - ☐ Sexual/Coercion
- ☐ Has felt afraid of or been threatened by a partner
- ☐ Has been attacked or sexually assaulted
- ☐ Has been physically or verbally assaulted

Do you feel safe in your current relationship? ☐ YES ☐ NO

Have you ever participated in professional counseling/therapy? ☐ YES ☐ NO

Are you interested in counseling/therapy referrals? ☐ YES ☐ NO

Is it okay to discuss anything in this section during your initial visit with any family that may be present? ☐ YES ☐ NO

Would you like to discuss any answers from this page at another time, in private? ☐ YES ☐ NO

Please make notes of anything else you would like for us to know about this section.

____

____

____

____

____

____

____

CLIENT: ________________________ DOB: ________________

FAMILY HISTORY

Please select any conditions that apply. Write in the **immediate** family member(s) affected by associated conditions.

- ☐ Heart Disease ____________
- ☐ High Blood Pressure ____________
- ☐ Stroke ____________
- ☐ Lung Disease ____________
- ☐ Cancer ____________
- ☐ Glaucoma ____________
- ☐ Diabetes ____________
- ☐ Epilepsy/Seizures ____________
- ☐ Thyroid Disease ____________
- ☐ GI Disease ____________
- ☐ Liver Disease ____________
- ☐ Kidney Disease ____________
- ☐ Osteoporosis ____________
- ☐ Clotting Disorder ____________
- ☐ Depression ____________
- ☐ Mental Illness ____________

GENETIC HISTORY

Please complete this section about you or your partners health, your parents or siblings.

- ☐ Twins ____________
- ☐ Congenital Heart Disease ____________
- ☐ Spina Bifida ____________
- ☐ Tay-Sachs Disease ____________
- ☐ Cystic Fibrosis ____________
- ☐ Hunting's Chorea ____________
- ☐ Metabolic Disorder ____________
- ☐ Autism ____________
- ☐ Hemophilia ____________
- ☐ Thalassemia ____________
- ☐ Sickle Cell Disease/Trait ____________
- ☐ Muscular Dystrophy ____________
- ☐ Cystic Fibrosis ____________
- ☐ Canavan Disease ____________
- ☐ Other Birth Defect ____________
- ☐ OTHER ____________

ALLERGIES/SENSITIVITIES

Select any allergies and associated reactions.

- ☐ Latex ________________________
- ☐ Adhesives ________________________
- ☐ Environmental

________________________ ________________________
________________________ ________________________
________________________ ________________________

- ☐ Foods

________________________ ________________________
________________________ ________________________
________________________ ________________________

- ☐ Medications

________________________ ________________________
________________________ ________________________
________________________ ________________________
________________________ ________________________