Total Maternal Support

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Doula Intake Form

I, (Print name)**X**_____, give my permission, for Total Maternal Support to take notes about me, including personal information I choose to disclose, and information regarding the labor and birth of my child and postpartum period. I understand that this information may be used for the purpose of doula certification or recertification and will be shared with the International Doula Institute. I realize that this information will be shared with the doula that is providing backup support as well if needed. I also understand that this information will anonymously be used by my doula for statistical purposes, and that my doula may use this information to provide me with a summary for my own personal use upon request.

Sign here: **X**_____

Date: _____

About You

Age: _____ DOB: _____/_____/_____ EDD: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

Email: _____

Occupation: _____

Employer: _____

Work Phone: (_____) _____-_____

Do you have other Children? Y / N If Yes, list below:

Name/s	Age/s

Household Members:

Name	Relationship

Childcare Plan for Labor: _____

_____

_____

_____

Pet Plan for Labor: _____

_____

_____

_____

Who can I thank for referring you to Total Maternal Support or how did you hear about us?

About Partner

Partner's Name: _____

DOB: _____/_____/ _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

Email: _____

Occupation: _____

Employer: _____

Work Phone: (_____) _____-_____

Email: _____

Attending Birth: Y/N

Would Like to be hands on? Y/ N

About Your Care Providers

Primary Provider: _____
Type of Practice (Private, Group, HMO): _____
Phone: (_____) _____-_____ Email: _____
Website: _____
Place of Birth: _____
Address: _____
Landmarks: _____
Phone: (_____) _____-_____
Back Up Provider: _____
Type of Practice (Private, Group, HMO): _____
Phone: (_____) _____-_____ Email: _____
Website: _____
Place of Birth: _____
Address: _____
Landmarks: _____
Phone: (_____) _____-_____
Home Birth Back-up Hospital (if applicable):

_____
Type of Practice (Private, Group, HMO): _____
Phone: (_____) _____-_____ Email: _____
Website: _____
Place of Birth: _____
Address: _____
Landmarks: _____
Phone: (_____) _____-_____

If applicable, have you toured your desired birthing facility? Y/N Pre-Registered? Y/N

Pediatrician: _____
Phone: (_____) _____-_____
Childbirth Classes? Y/N Educator: _____
Breastfeeding Classes? Y/N Educator: _____
Other Classes: Y/N Educator/s: _____

Support Information

Fears/Concerns about Pregnancy: Y/N Why: _____

_____
_____
_____
_____
_____

Fears/Concerns about Birth: Y/N Why: _____

_____
_____
_____
_____
_____

Trust caregivers? Y/N Why: _____

_____
_____
_____
_____
_____

Trust Hospital/home birth: Y/N Why: _____

_____
_____
_____
_____
_____

Age Concerns: Y/N Why: _____

_____
_____
_____

Reason for wanting a Doula: _____

_____
_____

Health Information

Pregnancy High-risk: Y/N Why: _____

Allergies: _____

Special Diet: Y/N _____

Vitamins: Y/N _____

Supplements: Y/N _____

Routine Meds (including OTC): _____

_____

Drink: Y/N Quantity/Frequency: _____

Smoke: Y/N Quantity/Frequency: _____

Drugs: Y/N Quantity/Frequency: _____

Exercise: Y/N Frequency: _____

(check any applicable)

___ Anemia ___ Asthma ___ Anorexia/Bulimia ___ Kidney Infections ___ Bleeding Disorders ___ Cancer ___ Conization/LEEP ___ Diabetes ___ Epilepsy ___ Fibroids ___ Heart Disease ___ Hepatitis ___ Herpes ___ HIV/AIDS ___ Hypoglycemia ___ Hyper/Hypotension ___ STD's ___ TB ___ Thyroid Disorders ___ Ulcers ___ Varicosities ___ Vaginal Infections
__Other _____

Medical History

Any major surgeries, injuries, hospitalizations: Y/N

_____

History of emotional problems: Y/N

_____

Any history of personal trauma (rape, abuse, etc): Y/N

_____
_____

Pre-pregnancy PMS: Y / N Pain/Cramping: Y / N

Coping techniques: _____

Planned Pregnancy: Y / N

Feelings About Pregnancy:

_____

_____

Difficulty Conceiving: Y / N Special technology used: Y / N (i.e IVF etc)

Prior Pregnancies: Y / N

Any Miscarriages:	Any Abortions:	Live Births:

Pregnancy History:

DOB (Mo/yr)	# of Weeks along	Sex f/m	Weight lbs./oz	Length In.	Meds/Interventions/ Complications	Outcome	Multiplies

Have you breastfed before? Y/N Duration: _____

Have you experienced any problems with breastfeeding? Y/ N If yes, explain below:

_____

_____

Have you ever had postpartum depression? Y/ N

What symptoms did you experience, if any?

_____

How did you cope? _____

Experience any of the following? (Check all applicable)

___ Acid Indigestion ___Anxiety ___ Carpal Tunnel Syndrome ___ Bowel Problems __Preterm Labor ___ Depression ___ Fatigue ___ Hemorrhoids ___ Incontinence ___ Insomnia ___ Muscle Cramps/Spasms ___ Nausea/Vomiting ___ Shortness of Breath __UTI __Hypertension ___Swelling/Edema ___ Other:

Any other pregnancy complications? Y/ N If yes, what complications?

_____

_____

Prenatal Screening

Had an ultrasound? Y / N

Results:

_____

_____

Other prenatal screening: Y / N _____

Results: _____

Group B Strep? Y / N Diagnosed when: _____

Result: _____

Gestational Diabetes : Y / N Diagnosed when: _____

Result: _____

STD/I's: Y/ N Diagnosed When: _____

Results: _____

Birth Desires

Type? __Unassisted __Lotus __Unmedicated __Vaginal __ Cesarean section

Setting? __ Hospital __ Home __ Birthing center

What is your vision for this birth?

_____

_____

_____

What are your expectations of your Doula?

_____

_____

_____

_____

Where in your body do you usually feel tension?

_____

How do you manifest tension?

___ Difficulty breathing ___ Sweating ___ Panic___ Nausea ___ Moaning ___ Grinding teeth

___ Clenching fists ___ Racing heart ___ Anxiety___ Other: _____

How do you comfort yourself when experiencing stress or pain:

(Check all applicable)

___ Distraction ___ Movement ___ Silence___ Turing inward ___ Self-medicating behaviors

___ OTC drugs___ Hot/cold packs ___ Companionship ___Other:
_____

What is your plan for coping with the pain of labor?

_____

_____

Which medical procedures/intervention are you open to, if any?

(Check all applicable)

___Bed Rest/Recumbent Position ___Electronic Fetal Monitoring (Efm) ___Limited Oral Intake During Labor ___Vaginal Exams ___Inductions/Augmentations ___Amniotomy ___Regional Anesthesia ___Catheterization ___Iv Fluids ___Episiotomy ___Instrumental Birth ___Cesarean

Would you like more information about the options? Y/ N

How would you like your doula to respond if you are requesting pain medications?

_____

Do you have a birth plan already? Y / N Is it signed by your caregiver? Y / N

Do you want photos/videos taken? Y / N Photos Only / Video Only/ Both

When is appropriate? Before Birth / During Labor / After Birth

Please sign your name below if you consent to me taking photos or videos
X_____

Please sign your name below consenting to photo release giving permission to share photos and videos for educational, promotional, and/or marketing purposes

X_____

Is there anything else I should know to best support you? Y/ N

_____

_____

_____

Are there any cultural/religious choices/preferences that may affect your birth? Y/ N

_____
_____
_____

Please check any you are interested in:

___ Aromatherapy ___ Scalp massage ___Rebozo ___Intimate alone time with partner ___Dim lighting ___Music ___Water birth ___Water labor ___Foot soak ___Counter pressure ___Post-partum support ___Breastfeeding counseling ___Pelvic floor specialist ___Chiropractic Care ___Cleaning services ___ Mother support group ___Belly binding ___Meal Train ___Essential oils ___V steam ___Therapy
___Community Resources For: _____
___Other: _____

Referrals: