Total Maternal Support

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7067506472 [text/call]

Postpartum Needs Assessment

Date ____________________________________

Name ____ DOB ____________________

Occupation ______________________________ Email _________________________________

How long off work ____

Partner Name____

Occupation ______________________________ Email _________________________________

How long off work ____

Home Address____

City _____________________________________ State ____________ Zip _______________

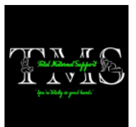
Phone__________________________________ Cell Phone _____________________________

Can I Text you? Yes No Can voicemails be left? Yes No

Other children names and ages ____

____

____



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Others who live in your household ____

____

____

Any Pets in the home? Yes No

Where specifically did you hear about TMS? _______________________________________

Do you expect any other help from anyone else? ___________________________________

____

____

Are you interested in: Overnight care Daytime care Both

Planned method of feeding: Breastfeeding Formula Pumped Breastmilk

Planned Sleep Arrangements: ____

____

What sorts of things are you expecting from your postpartum doula? **(Bubble all that apply)**

- Caring for baby and home while family sleeps
- Assistance/education with infant care
- Breastfeeding support/education
- Running errands
- Assisting in household organization
- Organizing nursey for infant care
- Household laundry
- Meal/snack prep
- Grocery shopping
- Appointment attendance
- Help with older siblings
- Assistance with pets
- Other:

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Any Cultural/ Religious preferences that may affect your postpartum time?

Anything else I should know to better support you?

Any special family circumstances?

Any classes taken?

Do you feel that you have a certain parenting style that you will/do prescribe too?

Have you read any parenting books? Yes No
Which Ones?

What are your expectations of your doula?

Fears/Concerns about postpartum time.

Reason for wanting a doula.

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Disclaimer: I am not a medical professional; I am asking questions about your medical history to better understand you as whole person to better support you.

Primary Care Provider ____

Back up Provider ____

Place of Birth ______________________________ Phone ____________________

Pediatrician ______________________________ Phone ____________________

Hospital preference in case of emergency ______________________________

Allergies (drugs, food, latex) ______________________________________

Specific Diet/Limitations ______________________________________

Taking Any Vitamins ____________________ Taking Any Supplements ____________________

Routine Meds including OTC ____________________ Placenta encapsulation ______________

Drink/Smoke/ Drugs? Yes No Frequency? Occasionally Daily

Exercise? Yes No Frequency? Occasionally Daily

Check any applicable:

_ Anemia _Asthma _Anorexia/Bulimia _Bladder/ Kidney Infections _ HIV _ Cancer _STD's
_Bleeding disorders _Diabetes _Epilepsy _Fibroids _Heart Disease _ Hepatitis _Tuberculosis
_Herpes _Hypoglycemia _ Hyper/Hypotension _Thyroid Disorders _Ulcers _ Varicosities
_Vaginal Infections _Anxiety _Depression _Emotional Problems

Any major surgeries, injuries, hospitalizations______________________________

Personal Trauma (rape, abuse, etc.) Yes No ______________________________

Planned Pregnancy____________________ Feelings Now____________________
Difficulty Conceiving ____________________ Technology/interventions Used______________

Pregnancies______________ Births ______________ Losses______________

Breastfed Before Yes No Any Issues______________________________

____

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Check any applicable:

_Acid Indigestion _Anxiety _Carpal Tunnel Syndrome _Bowel Problems _Fatigue
_Hemorrhoids _Incontinence _Lack of Sleep _ Muscle Cramps _ Nausea
_Vomiting _Shortness of breath _Swelling/Edema _Gestational Diabetes
_Group B Strep

Any Complications____

____

Any resources you're interested in **(check all applicable)**:

- o Mental Health
- o Chiropractic
- o Pelvic Floor specialist
- o Help with baby items
- o Help with bills

Will you be utilizing any meal prep companies? _______________________________________

o I'd like references

Will you be utilizing any cleaning service? ____

o I'd like references

Will you be utilizing any laundry service? ____

o I'd like references

Are you interested in a meal train organization? Yes No I need more info

If you expect that your doula will go shopping for you, please provide a prepaid visa card. Your doula will provide a receipt for each purchase made and will return prepaid card at the end of the service. Please understand no personal debit nor credit cards will be utilized even with your permission. **Initial X**_________

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Where do you typically buy groceries? Can groceries be delivered?

1.   2.   3.

Favorite delivery restaurants?

1.   2.   3.

Favorite dinner meals?	Favorite snacks?	Favorite breakfast?
1.	1.	1.
2.	2.	2.
3.	3.	3.
4.	4.	4.
5.	5.	5.
6.	6.	6.
7.	7.	7.
8.	8.	8.
9.	9.	9.
10.	10.	10.

Services Requested **(Check all applicable):**
__Grocery Shopping __Meal Preparation __Meal Cooking __Light Kitchen work
__Meal planning __ Other: ____