

Doula Client Intake

Birthing person's name:			
Phone number:		Receive texts?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Email address:			
Mailing address:			
Support Person(s):			
Phone number:		Receive texts?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Email address:			
Care provider name:			
Planned location of birth:		Have you taken a tour?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Estimated due date:			

Please list any test results or restrictions that have been placed on you or your pregnancy:

What number pregnancy is this for you? _____ Number of previous births: _____

Have you taken a childbirth class? ☐ Yes ☐ No

If Yes , which one and with whom?	
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Other classes?

Do you have a birth plan? ☐ Yes ☐ No

Postpartum plan?

☐ Yes ☐ No

Would you like help with these? ☐ Yes ☐ No

Have you shared with your provider?

☐ Yes ☐ No

Names others you want to be with you at birth:	Anyone you do not wish to be with you:

When you are anxious or nervous how does your body respond? *(check all that apply)*

- | | |
|---|--|
| <input type="checkbox"/> Fidgeting | <input type="checkbox"/> Grinding teeth/clench jaw |
| <input type="checkbox"/> Rapid heart beat | <input type="checkbox"/> Hyperventilation |
| <input type="checkbox"/> Sweating | <input type="checkbox"/> Nausea/vomiting |
| <input type="checkbox"/> Breath holding | <input type="checkbox"/> Nail biting |
| <input type="checkbox"/> Other(s): _____ | |

Where does your body manifest tension? *(check all that apply)*

- | | |
|--|-------------------------------------|
| <input type="checkbox"/> Back | <input type="checkbox"/> Jaw |
| <input type="checkbox"/> Forehead | <input type="checkbox"/> Chest |
| <input type="checkbox"/> Neck/Shoulders | <input type="checkbox"/> Lower body |
| <input type="checkbox"/> Other(s): _____ | |

What do you use to cope with stress or pain? *(check all that apply)*

- | | |
|--|---|
| <input type="checkbox"/> Distraction | <input type="checkbox"/> Bath/Shower |
| <input type="checkbox"/> Sleep | <input type="checkbox"/> Massage |
| <input type="checkbox"/> Activity/Exercise | <input type="checkbox"/> Hanging with partner/friends |
| <input type="checkbox"/> Music | <input type="checkbox"/> Being alone |
| <input type="checkbox"/> Other(s): _____ | |

Knowing that everything is flexible, what are your preferences for coping with labor?

Are there any words or phrases you would prefer I not use? Any words you want me to use?

Do you have any religious or cultural beliefs of which you would like me to be mindful?

Anything else you would care to share?