

Client History

(Please share as much or as little as you like with me)

Mother's Information

Name: _____ DOB: _____ EDD: _____

Address: _____

Phone

(H): _____ Phone(W): _____ Other: _____

Occupation: _____ Employer: _____

Partner's Information

Name: _____ DOB: _____

Address: _____

Phone(H): _____ Phone(W): _____ Other: _____

Occupation: _____ Employer: _____

Care Provider Information

Mother's Care

Provider: _____ Phone: _____

Birth Site: _____ Phone: _____

Others to Attend the Labor/Birth:

Name	Relationship	Special Needs
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Childbirth Educator: _____

Pregnancy History

of Pregnancies _____ # of Births _____

Any difficulty becoming pregnant?

Any spotting?

Excessive nausea/vomiting?

Prenatal care started when?

How often do you see your care provider?

Any special tests?

Abnormal AFP/Glucose?

Special diet?

Reliability of due date?

Previous Pregnancy/Birth Information

Any C/Sections?

Any stillbirths/late losses?

Traumatic Birth?

Describe your prior birth(s), include what you'd like different this time.
What is the most important thing to you about the birth?

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Are you currently taking any medication (list)?

Have you ever been hospitalized?

(Why, when, where) _____

Have you ever had surgery?

Have you ever had any serious injury?

Have you ever been treated for emotional/psychological/psychiatric problems?

Are there any relationship conflicts you'd like me to be aware of?

****IMPORTANT**** If you have ever been emotionally, physically, or sexually abused in any way, it would be to your benefit to share that information with your doula so she can provide the special support you may require. You can do this verbally if you wish.

Which areas of your body would you say you feel the most stress? (Circle any that apply)

Forehead

Jaw

Neck

Shoulders

Back

Chest

Arms

Hands

Legs

OTHER:

Client: _____

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In nervous or painful situations, do you experience any of the following:

Fast heart beat

Chills

Shaking

Nausea

Vomiting

Clenched fists

Sweating

Tapping feet

Restless legs

Nail biting

Grinding teeth

Other:

Please indicate ways in which you've managed/coped with stress in the past:

Have you selected a primary care provider for the baby?

Will you BREAST FEED or BOTTLE FEED?

IF BREAST FEEDING:

Have you breast fed before?

Any problems?

Have you taken a breast feeding class?

Read Books/Articles?

Do you have any concerns about inverted nipples?

Other worries about breast feeding problems?

Do you have a breast pump?

If your baby is male, do you plan to have him circumcised?

Are you interested in more information about circumcision?

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Do you have everything you need to care for your baby?

Do you have any concerns about being able to adequately care for the baby?

Do you have experience in infant care?

Did you take a baby care class?

Will someone be available to help care for you and the baby for a few days following the birth?

Are you interested in post-partum doula services?

Is there anything else you would like to share with me?