



Client Information Record

Today's Date _____

Estimated Guess Date (Due Date) _____

Doctor/Midwife _____

Planned Birth Location _____

Primary doula _____

Backup Doula _____

ABOUT YOU:

Name _____ DOB _____

Occupation _____ Place of Work _____

Partner _____ DOB _____

Occupation _____ Place of Work _____

Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Mom: Work/Cell Phone _____ Email _____

Dad: Work/Cell Phone _____ Email _____

How long have you been together? _____

Children's names, sex & ages _____

Pets and Names _____

Plan for care of children during birth _____

Plan for care of pets during birth _____

Others who live in your household and ages _____

Names & relationship of those who may be with you during birth _____

Who referred you to our services? _____

ABOUT YOUR HEALTH CARE PROVIDERS:

Primary Provider (Doctor/Midwife) _____

Planned Place of Birth _____



Have you taken a tour? _____ Registered? _____

Baby's Health Care Provider (Pediatrician/GP) _____

Taken Childbirth Classes? _____ With Whom? _____

Breastfeeding Classes? _____ With Whom? _____

Other classes? (Exercise, Parenting, CPR, Yoga, etc.) _____

Other Health Care Providers You See (Chiropractic, Massage, Acupuncture, Homeopathy, Naturopath, Therapist, etc.) _____

ABOUT YOUR MOM'S FAMILY:

Your Mother's Childbearing History: # of pregnancies _____ # of births _____

Any difficulties? (Premies, Caesarians, Stillbirths, Bleeding, Multiple, Diabetes, Congenital Anomalies, etc.) _____

How were her births? (Early, Late, Short, Long, Easy, Hard) _____

Breastfed? _____ how long? _____ Problems? _____

Attitudes about your pregnancy and about pregnancy and birth in general _____

Where does your family live? _____ What are their plans regarding involvement with the Birth and/or Postpartum Period? _____

ABOUT YOUR PARTNER'S FAMILY:

Your Mother's Childbearing History: # of pregnancies _____ # of births _____

Any difficulties? (Premies, Caesarians, Stillbirths, Bleeding, Multiple, Diabetes, Congenital Anomalies, etc.) _____

How were her births? (Early, Late, Short, Long, Easy, Hard) _____

Breastfed? _____ how long? _____ Problems? _____

Attitudes about your pregnancy and about pregnancy and birth in general _____

Where does your family live? _____ What are their plans regarding involvement with the Birth and/or Postpartum Period? _____

ABOUT YOUR HEALTH HISTORY:

How is your health? _____

Any Allergies? (Drugs, Food, Latex, etc.) _____

What is your diet? _____

Are you a vegetarian? _____

Vitamins _____ Supplements _____

Routine Medications, Including OTC _____

Do you drink alcohol? _____ Quantity/Frequency _____

Do you now smoke? _____ Quantity/Frequency _____

Do you use any other drugs/substances now or at any time during this pregnancy? _____

Present Exercise and Frequency _____

Are you currently receiving care for any medical condition not related to your pregnancy? _____

If so, what? _____ Taking any medications? _____

Have you ever taken medication for or been hospitalized for emotional problems? _____

ABOUT YOUR PREGNANCY:

Menstrual History

Length of Cycle _____ Days of Flow _____ Regular/Irregular _____

PMS symptoms _____ Coping Techniques _____

Conception History

Was this a planned pregnancy? _____ How do you feel about it now? _____

Any difficulty conceiving? _____ Any special technology used? _____

Method of Birth Control Prior to Conception _____

Childbearing History

of pregnancies _____ # of births _____

Prior Pregnancies and Births (use back for details &/or additional births)

DATE	WEEK # (Gestation)	SEX	WEIGHT	NAME/OUTCOME	LABOR LENGTH	MEDS, INTV, ETC.

Do you plan to breastfeed? _____ if so, for how long? _____

What are your questions about breastfeeding? _____

Have you breastfed before? _____ Any problems? _____

Have you ever had Postpartum Depression/anxiety? _____ Has another family member? _____

History of this Pregnancy

Estimated Guess Date _____ Based on: LMP or Ultrasound (when? _____) Other? _____
 Has this changed? _____

Check Any That Apply Now:

- Acid Indigestion
- Anxiety
- Carpal Tunnel Syndrome
- Constipation/Diarrhea
- Fatigue/Tiredness
- Hemorrhoids
- Incontinence
- Lack of Sleep
- Muscle Cramps
- Nausea and/or Vomiting
- Shortness of Breath
- Swelling

Any Medical Complications with this Pregnancy? _____

Prenatal Screening

Have you had an Ultrasound? _____ How many? _____ Comments? _____
 Strep B status? _____

Other Prenatal Screening? (Amnio, Vaginal Ultrasound, Rh, Genetic Testing.) _____

YOUR PLANS FOR THIS BIRTH:

What do you usually do when coping with pain and/or stress? _____

What makes you feel safe? _____

If you could have your ideal birth: what would it look like? (You can draw a picture if you want)

You: _____

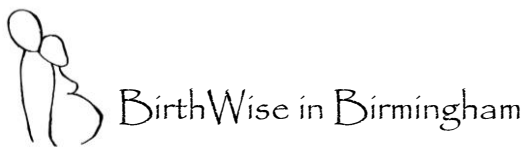
Partner, what would be your ideal role, activity during labor and birth? _____

When would you like to arrive at the hospital: at what stage of labor _____ how far dilated? _____

What do you plan to do while laboring at home? _____

What is your coping plan for in the hospital? _____

What do you want me (doula) to do? _____



Any special ideas for what you might like in labor? (sight, smell, sound, touch, taste) _____

Any special positions, breathing or relaxation techniques you have practiced or would like to use? _____

Do you have a Birth Plan? _____ Reviewed with Caregivers? _____

Are you planning on photos? _____ Video? _____

Are you planning on having music? _____ Have you made a playlist? _____

If you have given birth before, did you use a doula? Y / N

What did she do that was helpful (or not helpful) for you and your partner?

Is there any other question I should have asked you and didn't? Or is there anything else you think I should know? _____

Thank you!

Revised 12/19/2016