BirthWise in Birmingham

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____

BirthWise in Birmingham

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? (Preemies, 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? (Preemies, 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!

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