

CLIENT INFORMATION RECORD
Doula

Today's Date _____ EDD _____ Doctor/Midwife _____ Birthplace _____

ABOUT YOU

Name _____ DOB _____

Occupation _____ Place of Work _____

Partner _____ DOB _____

Occupation _____ Place of Work _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Fax/Pager _____

Mother's Work Phone _____ Partner's Work Phone _____

How Long Have You Been Together? _____

Father of Baby (if Other Than Partner) _____

Sibling's Names and Ages _____ Pets and Names _____

Others Who Live in Your Household & Ages _____

Plan for Care of Children During Birth _____

Plan for Care of Pets During Birth _____

Others Who May Be With You During Your Birth _____

Who Referred You to My Service? _____

Directions to Your Home _____

ABOUT YOUR HEALTH CARE PROVIDERS

Primary Provider (Doctor/Midwife) _____

Type of Practice (Private, Group) _____ Phone _____

Back-Up Provider(s) and How Arranged _____

Planned Place of Birth _____ Phone _____

Back-Up Hospital if Home Birth/Birth Center _____

Have You Taken A Tour? _____ Registered? _____

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

Taken Childbirth Classes? _____ With Whom? _____

Breastfeeding Class? _____ With Whom? _____

Other Classes? (Exercise, Parenting, CPR, etc.) _____

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

ABOUT MOM'S FAMILY

Your Mother's Childbearing History: Gravida _____ Para _____ Breastfed? _____

Any Difficulties? (Preemies, Cesareans, Breech, Stillbirths, Bleeding, Multiple, Diabetes, Congenital Anomalies...)

How Were Her Births? (Early, Late, Long, Short, Easy, Hard) _____

Attitudes About Your Pregnancy and About Pregnancy and Birth in General _____

Where Does Your Family Live? _____

Plans to be Involved with Birth and/or Postpartum Period? _____

ABOUT PARTNER'S FAMILY

Your Mother's Childbearing History: Gravida _____ Para _____ Breastfed? _____

Any Difficulties? (Preemies, Cesareans, Breech, Stillbirths, Bleeding, Multiple, Diabetes, Congenital Anomalies...)

Attitudes About Your Partner's Pregnancy and About Pregnancy and Birth in General _____

Where Does Your Family Live? _____

Plans to be Involved With Birth and/or Postpartum Period? _____

ABOUT MOM'S HEALTH HISTORY

How is Your Health? _____

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

What is Your Diet? (Vegetarian, Type, Source of Protein) _____

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 During Pregnancy? _____

Present Exercise and Frequency _____

How is Your Health? _____

Are you receiving care for any medical condition other than your pregnancy right now? _____

If so, what? _____ Taking any medications? _____

Have You Ever Taken Medication for or Been Hospitalized for Emotional Problems? _____

Optional: Any History of Personal Trauma (Abuse, Rape, Incest, etc.)? _____

ABOUT YOUR PREGNACY

Menstrual History

Length of Cycle _____ Days of Flow _____ Regular/Irregular _____ Scant, Avg, or Heavy Flow _____

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

Gravida _____ Para _____ TAB _____ SAB _____ TPAL _____

Prior Pregnancies and Births (Use Narrative Page for Details & Additional Births)

DATE	WEEK#	SEX	WT	NAME/OUTCOME	LABOR LENGTH	MEDS, INTV, COMPL

Have You Breastfed Before? Any Problems? _____

Have You Ever Had Postpartum Depression? _____ Mother/Sisters? _____

History of This Pregnancy

EDD _____ Has this Date Been Changed? _____ Reason? _____

LMP _____ LNMP _____ Conception/Ovulation _____ Quickening _____

1ST FHT's _____ Method _____ Mother's Blood Type _____ Father's Blood Type _____

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 this Pregnancy? _____

Prenatal Screening

Have You Had an Ultrasound? _____ How Many? _____ Results? _____

Other Prenatal Screening? (Amnio, CVS, Vaginal Ultrasound, Rh Titers, AFP or Triple Screen, Genetic Testing...)

ABOUT YOUR BIRTH

Mother: What is Your Vision for this Birth? (Please be specific) _____

Partner: What is Your Vision for this Birth? (Please be specific) _____

What are Your Expectations of Your Labor Assistant/Doula/Labor Support Provider? _____

What is Your Plan for Coping With the Potential Pain of Labor? _____

Do You Have a Birth Plan? _____ Reviewed with Caregivers? _____

Are You Planning on Photos (Color/Black & White)? _____ Video? _____

Are You Planning on Having Music? _____ Do You Need a Player? _____

Any Special Ideas About What You Might Like for Labor? (Sight, Sound, Smell, Taste, Touch) _____

Any Special Positions, Breathing or Relaxation Techniques You Have Practiced or Would Like to use? _____

Anything Else You Would Like Us/Me to Know to Best Support You? _____
