



Birth Client Intake Form

Name _____ D/O/B _____

Spouse/Partners name _____

Address _____

Profession _____ phone _____

Email address _____

How did you hear about me? _____

Doctor's name _____

Doctor's phone number _____

Which pregnancy is this numerically? _____

Your expected birth date _____

Hospital giving birth at? _____

To your knowledge do you have:

- Pre-Eclampsia _____
- Threatened Miscarriage _____
- Placental Dysfunctions _____
- Eclampsia or Toxemia _____
- Gestational Diabetes _____
- Urinary Tract Infection _____
- Other Infections _____
- Any Allergies _____
- Heart Disease _____
- PCOS _____
- Hepatitis _____
- Auto Immune Deficiency _____
- Herpes _____
- HIV _____
- AIDS _____

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Have you had any difficulties during this pregnancy?_____

Please list any medications you are taking now _____

Please tell me briefly what the ideal Birth Experience for you would be ____

Please tell me briefly what you will expect from your Doula?_____

Is there anything else you think I should know about your, your spouse, or your immediate family/circumstances?

I, the undersigned hereby agree that the aforementioned information is true to the best of my knowledge. I understand that my treatment will be that of emotional, physical and informational support. I also give my permission to receive this emotional, physical and informational support.

Signature_____Date_____