|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Client name:** |  | | | **Date of Birth:** | |  | |
| **Address Line 1** |  | | | **Address line 2** | |  | |
| **Town** |  | | | **Post code** | |  | |
| **Gender** |  | | | **Marital Status** | |  | |
| **Mobile (or Main)** |  | | | **Emergency contact** | |  | |
| **Occupation** |  | | | **Email Address** | |  | |
| **Referred by** |  | | | **Date of First  Appointment** | |  | |
| **About your pregnancy and birth expectations** | | | | | | | |
| Expected Due date | | |  | | | | |
| Place of Birth (hospital, home birth, midwife led unit) | | |  | | | | |
| Number of previous pregnancies and births | | |  | | | | |
| Previous Birth History (if relevant) | | |  | | | | |
| Previous experience and/or current feelings/concerns about birth and labour | | |  | | | | |
| Do you have religious or cultural preferences relating to your birth experience? | | |  | | | | |
| Will anyone else be present for your labour and/or birth (other than doula)? What will their role be? | | |  | | | | |
| How do you feel about pain medication? | | |  | | | | |
| Do you have a birth plan? | | |  | | | | |
| What are your thoughts about breastfeeding? | | |  | | | | |
| **Birth Doula Services** | | | | | | | |
| Why are you interested in having a doula for your birth? **Please list in order of priority importance to you**. | |  | | | | | |
| What are your expectations from your doula? | |  | | | | | |
| **Health information (in relation to pregnancy)** | | | | | | | |
| Any cervical/lower abdominal surgery? | | Yes / No If yes, please briefly describe: | | | | | |
| Are you currently taking any medication, herbs or supplements? | | Yes / No If yes, please list by condition: | | | | | |
| Briefly describe the current pregnancy history | |  | | | | | |
| **General Health Status – For multiple choice, please circle, bold, or delete as relevant** | | | | | | | |
| **Height** | |  | | | **Weight** | |  |
| **Energy level** | | Good / moderate / poor / erratic | | | **Appetite** | | Good / moderate / poor / erratic |
| **Sleep Onset** | | Fast / takes time / erratic | | | **Sleep Quality** | | Good / moderate / poor / erratic |
| **Bowel Movement** | | Regular / irritable / constipated / erratic | | | **Breathing** | | Asthma / Other (describe) |
| **Nervous System** | | Stroke / Fainting / Dizziness / Numbness Pins & Needles /Other | | | **Heart / Circulation / Blood Pressure** | | High BP / Low BP / Arrhythmia /Heart Attack / Other: |
| **Typical diet** | |  | | | **Mealtimes** | | Regular / erratic / eat late in the evening |
| **Do you drink alcohol? How many units/week?** | | Yes / No | | | **Do you smoke? How much?** | | Yes / No |
| **Do you drink caffeine? How much per day?** | |  | | | **Exercise Type & frequency** | |  |
| **Family Medical History** | | | | | | | |
| **Please list any health conditions that may be relevant:** | | Mother: | | | | | |
| Female Sibling or relatives: | | | | | |
| The above information is correct and complete and I am willing to provide further information in follow up sessions.  **Signed and date** | | | | | | | |