

# Birth Doula New Client Intake Form

## GENERAL INFORMATION

Name \_\_\_\_\_

Partner's Name \_\_\_\_\_

Home Address \_\_\_\_\_

E-mail \_\_\_\_\_

Phone Number (cell) \_\_\_\_\_

Partner/Other Phone Number \_\_\_\_\_

Partner/Other E-mail \_\_\_\_\_

Your Birth Date \_\_\_\_\_

Emergency Contact Name/Relationship \_\_\_\_\_

Phone Number \_\_\_\_\_

## BIRTH/CURRENT PREGNANCY INFORMATION

Baby's Due Date \_\_\_\_\_

Are you expecting multiples (twins, triplets, etc.)? ☐ Yes ☐ No

Gender of the Baby (circle the applicable answer)

Girl    Boy    One of Each (twins)    Don't know yet

Do you have a name picked out? If yes, you can share it with me here if you like

\_\_\_\_\_

Do you plan to share the name with others? (circle the applicable answer)

Yes    No    We would like it to be a surprise for some people so please don't share!

Have you taken, or are you planning on taking, any childbirth education classes? If so, what classes and where will/did you attend them?

\_\_\_\_\_  
\_\_\_\_\_

What type of birth are you hoping for? (circle the applicable answer)

Vaginal  
cesarean birth

VBAC  
elective induction

induction for medical reasons  
water birth

Do you plan to birth (circle the applicable answer)  
Naturally (comfort measures/no pain medication)  
Epidural  
Other pain medication

Have you had any of the following pregnancy-related health conditions in your current pregnancy?

Rh incompatibility	Preterm Labor	Group B Strep
Hyperemesis Gravidarum (excessive vomiting)	Intrauterine Growth Restriction (IUGR)	Gestational Diabetes
Gestational Hypertension (high blood pressure during pregnancy)	Low Birth Weight	Placenta Previa
Pre-Eclampsia	Macrosomia (large baby)	Vena Cava Compression
	Polyhydramnios	Genetic Disorder
	Oligohydramnios	None of the above

Please list any conditions you have that are not listed above

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Maternity Healthcare Provider \_\_\_\_\_

Type of Provider:    Midwife        Doctor        Other (please specify)

Address \_\_\_\_\_

Phone Number \_\_\_\_\_

Location where you plan to deliver?    Home        Hospital        Birth Center    Other

Name and address of delivery location (or backup hospital if you plan to deliver at a birth center or at home)

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Do you have health insurance? \_\_\_\_\_

Will this be your first birth?    ☐ Yes    ☐ No

If you have had previous births, what were they like? What about those births would you like to be the same or different this time?

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Do you have any specific concerns or worries regarding this birth? And your partner?

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What are you most excited about for this birth? And your partner?

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Do you have any spiritual or philosophical beliefs or traditions that you would like to be respected during this birth?

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Who will be joining you for the birth (partner, friend, sister, mother, birth photographer, etc.)?

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Do you feel comfortable and at ease with everyone on your team?

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What support would you like from each member of your birth team? Anything specific?

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Are there any special circumstances with this pregnancy that may affect your plan for the birth?

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What is your idea of my role as a doula? What is most important to you in terms of birth doula support?

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Are you considering water birth? \_\_\_\_\_

**BIRTH WISHES**

Do you have a birth plan/vision? ☐ Yes ☐ No

*(If you have a birth plan/vision already, feel free to attach a copy to this form.)*

What are the 3 most important outcomes that you desire for this birth?

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What type of comfort measures do you think you would like to use during labor? (circle any or all)

Distractions

Water (tub/Shower)

Music

Breathing Patterns

Hot/Cold Therapy

Other techniques you would like

Massage

Visualization/Imagery

to use \_\_\_\_\_

Birth Ball

Focal Points

Walking, Dancing, Swaying

Aromatherapy

Are you planning on breastfeeding your baby? \_\_\_\_\_

Are there any topics that you would like to focus on during our prenatal visit(s)/conversations?

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**MEIDCAL INFORMATION**

Do you have allergies? (if yes, please list)

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Have you had any recent illnesses, surgeries, injuries, accidents, or trauma? (if yes, please describe)

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Do you currently take any prescription or non-prescription medications (herbs, natural supplements, vitamins, over the counter)? If yes, please list what you take and what it's for

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Do you currently have, or do you have a history of any medical or psychological conditions that will affect this birth?

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**PREVIOUS PREGNANCY INFORMATION**

How many times have you given birth? (twins, triplets, etc. count as 1 birth)

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Out of previous pregnancies, how many were carried to term (37 weeks +)?

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Out of previous pregnancies, how many were preterm (born 24 – 37 weeks)?

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How many children do you have? Please list name(s) and age(s)

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Have you given birth to multiples (twins, triplets, etc.)?

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Which types of births have you experienced? (circle all that apply)

This will be my first birth

Vaginal

C-section

VBAC (vaginal birth after

Cesarean)

Elective induction

Induction for medical reasons

Home birth

Hospital birth

Birth center birth

Water birth

How long did your previous labor(s) last?

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Have you had any of the following pregnancy-related health conditions in PAST pregnancies?

(circle all that apply)

Rh incompatibility

Pre-Eclampsia

Preterm Labor

Low Birth Weight

Macrosomia (large baby)

Polyhydramnios

Oligohydramnios

Group B Strep

Gestational Diabetes

Placenta Previa

Placental Abruption

Vena Cava Compression

Postpartum Hemorrhage

Postpartum Depression

Genetic Disorder

Intrauterine Growth Restriction  
(IUGR)

Hyperemesis Gravidarum  
(excessive vomiting)

Gestational Hypertension (high  
blood pressure during  
pregnancy)

None of the above

Please tell me anything you would like me to know about your past pregnancies

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Is there anything else you would like me to know as we begin working together?

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