CLIENT INFORMATION RECORD

*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? _____