PRE-PREGNANT/PREGNANT CLIENT INTAKE FORM

This information will be kept confidential

Please use additional pieces of paper if necessary and attach them to this form.

Name: Date: _____

Address:

C: H: W:

Email:

DOB: _____ Age: _____ Profession/past profession:

Please tick one or more of the following, are you:

PREPARING FOR PREGNANCY _____ ALREADY PREGNANT _____

INTERESTED IN LEARNING ABOUT PRENATAL BONDING _____

Do you have a partner at this time? Yes _____ No _____

PLEASE ANSWER THE FOLLOWING IF YOU ARE PREGNANT, OTHERWISE GO TO PAGE 2:

Is this your first child? YES _____ NO _____ If no please list names and ages of your children:

Was this child conceived naturally or through assisted reproductive technology, sperm donor, insemination, etc?

How many weeks pregnant are you, and how are you experiencing your pregnancy?

How did you experience your pregnancy/ies with your previous child/ren?

What kind of birthing experience/s did you have with your previous children?

What are your hopes and desires for your upcoming birth?

This information will be kept confidential

NAME: _____

THE FOLLOWING QUESTIONS ARE FOR PRE-PREGNANT AND PREGNANT WOMEN:

Have you ever lost a child to miscarriage, abortion, stillbirth, or death? Yes ____ No ____
If yes, please explain circumstances and dates and how this affects you today:

Do you have any medical conditions that would exclude you from physical activity in a session?
Yes _____ No _____ Please explain:

Height _____ Weight _____ Do you have any areas of your body that need special consideration?

Are you presently taking any medications or drugs? (name of medication, for what condition):

Are you presently using any recreational drugs, alcohol or nicotine? (amount per day/week):

What psychological or bodywork training have you had?

What kinds of psychological or bodywork therapy have you received, and for what period of time?

Are you in therapy or having regular bodywork? If yes, with whom? _____

Does this person have pre and peri-natal training/facilitation skills? Yes _____ No _____

List other physicians or health care practitioners you are being treated by:

List any other support you have?

This information will be kept confidential

NAME _____

Please check what you know or think applies to your birth history:

_____ an unmedicated vaginal birth in a hospital
_____ an unmedicated vaginal birth at home
_____ an anesthesia birth
_____ c-section
_____ a multiple birth
_____ other birth complications, please explain:

_____ with fetal heart monitor
_____ with cranial suction
_____ with forceps
_____ breech

_____ I had a twin that did not live. At what point pre or postnatally did your twin leave?
_____
_____ I was premature. How many weeks? _____
_____ I was in Neonatal Intensive Care Unit (NICU), Please state how long? _____
_____ I was incubated. How long? _____

Where was your father during the birth?

Were you separated from your mother at birth? (sent to nursery or NICU)?

Were you breast-fed? _____ if yes, for how long? _____

Men, were you circumcised as an infant? _____ If yes, was anesthesia used? _____

ABOUT YOUR OWN PRENATAL AND BIRTH EXPERIENCES:

Please tell me about any interventions shortly after your birth such as hospitalization for illness or jaundice, operations, illnesses as an infant or child.

Did either or both of your parents lose another child to miscarriage, abortion, stillbirth, or childhood death? If yes are you aware of how this affected you. Give dates and circumstances:

Who raised you – Your natural parents? Where you raised by a single parent? If your parents split up, how old were you? Did you have other primary care givers like grandparents, aunts, uncles, guardians, nannies or adoptive parents?

This information will be kept confidential

NAME _____

Do you or did you have siblings? Indicate ages relative to you, nature of relationship as children:

Please tell me any other information you know concerning **your conception**, your parents' attitude toward having you (planned, unplanned, wanted, confused, unwanted). If unwanted, did they consider or attempt abortion?

What do you know about **your life in the womb,** including physical effects (maternal or paternal smoking, drinking, drugs, mom's diet), and emotional effects including absence or presence of father during pregnancy or birth, parent's relationship with each other during your pregnancy, siblings' attitude toward your birth. If you are adopted, give information about transition in hospital and new family, as well as any birth history known:

Have you ever been or are you in an abusive relationship? Yes _____ No _____
If yes, please state when, what relation the person was or is to you, whether the abuse was or is physical, sexual or emotional. If a past relationship, what action did you take? If present, what are you doing about it? Please give details:

Have you, or anyone in your family of origin, been diagnosed with mental health issues, e.g. bipolar, schizophrenia, depression, etc? Yes _____ No _____ If yes, please explain:

Have you or anyone in your family taken prescribed medications for mental health issues? Yes ____ No ____ If yes, please explain:

Have you ever been hospitalized for mental health reasons? Yes _____ No _____ If yes, please describe the circumstances and outcomes with dates:

Has anyone in your family ever attempted or committed suicide? Yes _____ No _____ If yes, please describe the circumstances with dates:

Have you ever contemplated or attempted suicide? Yes _____ No _____ If yes, please describe the circumstances with dates:

Signature:_____ Date _____