Mother Blooming Birth Services & Midwifery

CLIENT INFORMATION

Please fill out this form as completely as possible. We will review it together at your next visit. Feel free to skip over any questions that are unclear. Please use ink and print clearly. Thanks.

Date_____

Your full name _____ Maiden_____

Birth Date_____ State of birth _____ E-mail _____

Address_____

Phone: home_____ work_____ cell_____

Your occupation_____ Marital status_____ SS#_____

Religious preference _____ Years of education completed _____

Partner/Father's full name_____ Years of education completed _____

Partner's Birth Date_____ SS#_____ Occupation_____

Address if different_____

Phone work _____ cell _____

Children's names/ages _____

How did you find us? _____

Is this your first out-of-hospital birth? Y / N Is this a planned pregnancy? Y/N

Your feelings about being pregnant:

Why do you want an out-of-hospital birth/midwife-attended birth?

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Name: _____

What do you see as the duties or responsibilities of your midwife?

Are there any particular ethnic, cultural or religious preferences for your care during pregnancy and birth that you'd like to discuss?

What sort of reactions have you received from family and friends about your plans to have an out of-hospital birth?

What are yours and/or your partner's main concerns about this birth?

How do you feel about going to the hospital if your midwife feels that complications are arising?

Who will be with you during your labor and birth?_____

Who will help you after the birth? _____

Do you plan to have children at your birth? Y/N

If yes, who will be there to attend to their needs? _____

Do you plan to breastfeed your new baby? Y / N How long?_____

We often encourage partners, kids, family and labor support people to come for some of your prenatal visits as well. Would you prefer that we meet alone instead? Yes / No / Sometimes

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Name: _____

These questions help us to determine if there are issues or topics that we need to discuss with you further.

Please answer the following questions by putting a circle around 'Y' yes or 'N' for no.

Y/N Do you think you are at increased risk for having a baby with a birth defect or genetic problem?

Y/N Are you or the FOB from any of the following ethnic/racial groups? Please circle all that apply:

Jewish Black/African Asian Mediterranean Aleutian Alaskan Other: _____

Y/N Have you ever been a health care or daycare worker?

Were you exposed to bodily fluids? Y/N

Y/N Have you ever used any drugs intravenously (IV) or had a blood transfusion?

Y/N Have you or the FOB had a sex partner who used IV drugs or had a blood transfusion?

Y/N Have you had 5 or more sexual partners in the past 5 years?

How often did you use a barrier method of birth control (male or female condoms)?

Circle one: always / usually / sometimes /never

Y/N Do you think you are at high risk for hepatitis or HIV/AIDS?

Have you had a recent HIV test? Y/N Date:_____

Y/N Have you ever been on medication for psychological problems?

Name of medication: _____ date _____

Y/N Have you ever been in an abusive relationship, or been abused (physically, sexually or emotionally)?

Y/N Do you feel safe in your home?

Y/N Has anyone ever told you, or do you think, you have ever used alcohol or drugs excessively?

Y/N Is there anything about your sexuality that you would like to discuss?

_____

_____

_____

If you've been pregnant before, tell me about your experience? _____

_____

_____

_____

_____

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Family History

Please indicate if anyone in your immediate family ever had any of the following, who and when.

- ❑ High Blood Pressure _____
- ❑ Cancer _____
- ❑ Diabetes _____
- ❑ Twins _____
- ❑ Severe emotional problems _____
- ❑ Alcohol, or drug abuse _____
- ❑ Other _____

Father of Baby/ F.O.B. (what & when)

- ❑ Sexually transmitted disease or infection _____
- ❑ Herpes infection Genital _____ Oral _____
- ❑ Severe emotional problems _____
- ❑ Alcohol, or drug abuse _____
- ❑ Tobacco use _____
- ❑ Other _____

Your Mother's pregnancy history

- ❑ Number of pregnancies _____ Number of births _____
- ❑ History of miscarriage _____
- ❑ Any complications _____
- ❑ Your weight at birth _____

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DIET AND NUTRITIONAL INFORMATION (you can fill this out after we decide to work together)

Has your appetite changed with this pregnancy? Y/N

How? _____

What is your feeling about weight gain during pregnancy? _____

Your partner's? _____Your parents' _____

Who cooks?_____

Please describe your diet (omnivore, vegetarian, vegan, no dairy, etc.) _____

Do you take a prenatal vitamin? Y/N Brand: _____,_____tablets/day:_____

Other supplements?_____

Do you receive food stamps? Y/N WIC Coupons? Y/N Other assistance?_____

How often do you usually eat? (include snacks) _____/day. Allergy restrictions?_____

Please record everything you eat and drink for 3 days. Include amounts, sizes, whole wheat or white, brand, etc.

Day #1, Date: _____

Breakfast: _____

_____

_____

AM Snack: _____

_____

Lunch: _____

_____

_____

PM Snack: _____

_____

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Dinner: _____

_____

_____

Bedtime Snack: _____

_____

How many glasses/oz of water did you drink? _____

Anything else you ate or drank? _____

Day #2, Date: _____

Breakfast: _____

_____

_____

AM Snack: _____

_____

Lunch: _____

_____

_____

PM Snack: _____

_____

Dinner: _____

_____

_____

Bedtime Snack: _____

_____

How many glasses/oz of water did you drink? _____

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Anything else you ate or drank? _____

Day #3, Date: _____

Breakfast: _____

_____

_____

AM Snack: _____

_____

Lunch: _____

_____

_____

PM Snack: _____

_____

Dinner: _____

_____

_____

Bedtime Snack: _____

_____

How many glasses/oz of water did you drink? _____

Anything else you ate or drank? _____

Y/N Do these 3 days represent your typical eating habits? If not, what was different?

_____

_____

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