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WomanWise client intake

Date	Name: First	Middle	Last	Maiden?
Phone: [home]		[work]	[cell]	
Race:		Religion:	Years education:	
Marital status:		Occupation:		
Date of birth:		State / Country of birth:		
Address:			City:	State: / Zip:
Inside city limits?	How long at this address?			
Partner:		Race:	Yrs. Educ.	Date of birth:
State / Country of birth:	Address (if different):		City:	State: / Zip:
Phone: (work/home/cell)	Occupation:	Father of baby: (if different than partner)		
Emergency contact: Name		Phone:	Relationship:	
Method of payment:		Social security #:	Partner SS#:	
Insurance information: Name or policy holder		Policy #:		Group #:
Email address(es):			Referred by:	

Please answer the following questions to help us have a better understanding of your health history & enable us to provide the best prenatal care possible. This information is completely confidential.

Family history / Indicate if anyone in your immediate family has ever had any of the below. If yes, who and when.

- ❑ High Blood Pressure
- ❑ Heart Attacks
- ❑ Diabetes
- ❑ Twins
- ❑ Birth Defects
- ❑ Cancer
- ❑ Mental Illness
- ❑ Alcohol/Drug Abuse
- ❑ Tuberculosis
- ❑ Other

Father of baby / Indicate if the baby's father has ever had any of the below. If yes, when.

- ❑ Sexually transmitted infections
- ❑ Genital/Oral Herpes
- ❑ Mental Illness
- ❑ Alcohol/Drug Abuse
- ❑ Tobacco use
- ❑ Other

Father's birth weight:

Your mother's history / Please answer the following regarding your mother.

- ❑ No. of pregnancies
- ❑ No. of births
- ❑ No. of Cesarean deliveries
- ❑ No. of premature births
- ❑ Miscarriages
- ❑ Complications
- ❑ ComplicationsDid she take DES when pregnant with you?
- ❑ Did she breastfeed?
- ❑ Your birth weight

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client intake

...continued.

Genetic history / Please circle appropriate

Yes **No** Has you or the father of the baby (FOB) ever had a baby with a birth defect or mental retardation? If so, please describe:

Yes **No** Do you or the FOB have any family members with birth defects or conditions diagnosed as genetic or inherited? If so, please explain:

Yes **No** Are you and the FOB related by blood? (e.g. cousins)

Yes **No** Are you or the FOB from any of the below racial or ethnic groups? (Circle)

Jewish / Black, African / Asian / Mediterranean

Yes **No** Do you think you are at increased risk for having a baby with a birth defect or genetic problem?

Medical history / Please indicate if you have ever had any of the below. If yes, when.

- ❑ Severe headaches
- ❑ Dental problems
- ❑ Blood clotting problems
- ❑ Hemorrhage
- ❑ Hemorrhoids
- ❑ Skin disorders
- ❑ Bowel problems
- ❑ Gall bladder problems
- ❑ Diabetes
- ❑ Kidney infection
- ❑ Seizures
- ❑ Surgeries
- ❑ Eye/Vision problems
- ❑ Thyroid problems
- ❑ Heart problems
- ❑ High blood pressure
- ❑ Tuberculosis
- ❑ Stomach problems
- ❑ Blood in stool
- ❑ Liver problems
- ❑ Hypoglycemia
- ❑ Arthritis
- ❑ Cancer
- ❑ Blood transfusions
- ❑ Ear/Hearing problems
- ❑ Rheumatic fever
- ❑ Anemia
- ❑ Varicose veins
- ❑ Asthma
- ❑ Ulcers
- ❑ Chicken Pox
- ❑ Hepatitis
- ❑ Bladder infection
- ❑ Pelvic or back injuries
- ❑ Hospitalizations
- ❑ Other

Yes **No** Do you have any allergies (drug or environmental)? Please list and describe severity & type of reaction:

Yes **No** Are you currently taking any medications or supplements? (prescription, herbal, vitamins & OTC)? Please list and describe (name, dosage, frequency, reason for taking):

Yes **No** Are you currently under the care of a physician or other health care provider(s) (including alternative care such as chiropractic, homeopathy, acupuncture, massage etc)? If yes, please list and describe (name & type of provider, reason for care, length of time in care, etc.)

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WomanWise

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Yes No Do you exercise regularly? If yes, please describe the type of exercise, how often, for how long, etc.

Gynecology history /

Age at first period

No. of days of bleeding

Cycle length (days)

Yes No Regular cycle

Yes No Pain/Cramping?

Yes No Do you examine your breasts? How often?

Yes No Do you douche?

When was your last Pap Smear?

Have you ever had an abnormal Pap? (Dates).

Please describe:

Please indicate if you have ever had any of the following. If yes, when.

- ❑ Yeast infections
- ❑ Bacterial vaginosis
- ❑ Syphilis
- ❑ Cervical surgery
- ❑ Fibroids
- ❑ Uterine Surgery
- ❑ Fertility problems
- ❑ Herpes: Oral Genital
- ❑ Notes:
- ❑ Trichomonas
- ❑ Chlamydia
- ❑ PID/pelvic infection
- ❑ HPV or Genital Warts
- ❑ Cervical polyp
- ❑ Endometriosis
- ❑ Breast lump(s)
- ❑ Other
- ❑ Group B Strep
- ❑ Gonorrhea
- ❑ Genital sores
- ❑ Cervicitis
- ❑ Ovarian Cyst
- ❑ Abnormal Bleeding
- ❑ Breast surgery

Have you ever experienced abuse?

Yes No Sexual

Yes No Emotional

Yes No Physical

Please share what you feel comfortable with:

Previous pregnancy outcomes /Please complete this table regarding your own pregnancies (from earliest to most recent).

Date ended (DOB)	No. weeks	Hospital/ Home/BC?	Comments (if birth: type of delivery?; weight and sex and name of baby; medications/intervention; length of labor, complications, length of breastfeeding etc.; if miscarriage or termination, note complications, type of procedure or surgery, if any)

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WomanWise client intake

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Present pregnancy /

Suspected date of conception:

Pregnancy test (date):

First day of last menstrual period (LNMP):

Yes No Normal?

Yes No Sure of LNMP?

Yes No Planned pregnancy?

Feelings about pregnancy:

Father and/or partner's feelings about pregnancy:

Most recent birth control used:

Contraception used in past; what, when, any problems?:

Please indicate if you have had any of the below problems during this pregnancy:

- ❑ Nausea
- ❑ Infections
- ❑ Indigestion
- ❑ Backache
- ❑ Diarrhea
- ❑ Abdominal/pelvic pain
- ❑ Bleeding gums
- ❑ Depression
- ❑ Work problems
- ❑ Vomiting
- ❑ Headache
- ❑ Leg cramps
- ❑ Swelling
- ❑ Non-food cravings (e.g. dirt, soap)
- ❑ Vaginal bleeding/spotting
- ❑ Varicose veins
- ❑ Loneliness
- ❑ Family/relationship problems
- ❑ Fever
- ❑ Dizziness
- ❑ Rash
- ❑ Constipation
- ❑ Urinary complaints
- ❑ Vaginal discharge
- ❑ Hemorrhoids
- ❑ Other

Notes:

Please indicate if you have used, experienced, or been exposed to any of the below during this pregnancy:

- ❑ Tobacco
- ❑ Marijuana
- ❑ Other meds
- ❑ Herbs
- ❑ Ultrasound
- ❑ Lead
- ❑ Cats
- ❑ Alcohol
- ❑ Cocaine
- ❑ Non-pres. Drugs
- ❑ Fumes/Sprays/Pesticides
- ❑ Measles/Viruses
- ❑ Vaccinations
- ❑ Raw meat
- ❑ Caffeine
- ❑ Street drugs
- ❑ Vitamins
- ❑ X-rays
- ❑ Mercury
- ❑ Travel
- ❑ Other

Notes:

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WomanWise

mother's questionnaire

Name: ______________________________

Congratulations on choosing a homebirth! It is our intention to provide you and your family with sensitive, personal care throughout the childbearing year. Many women find that issues concerning family influences, past experiences, and present circumstances surface during the pregnancy, birth and the postpartum period. We believe that open communication and a warm and trusting midwife/client relationship are essential and therefore encourage you to give consideration in answering the following questions. The issues brought up in this form will be discussed in greater detail during your prenatal appointments. Feel free to add any further comments or questions you may have to the end of this form. All information shared is confidential.

1 Why do you want to have this baby at home?

2 What do you see as the duties and responsibilities of your midwives?

3 What do you feel your responsibilities are regarding the pregnancy or birth?

4 What is your present understanding of complications that may occur during pregnancy or birth?

5 Our society does not always view homebirth and independent midwifery as "wise" or "safe" choices. You may find that family, friends and strangers respond to your plans to have a homebirth with comments like "but that's dangerous" and "why are you putting yourself and your baby at risk?" How would you respond to comments like these? What support, tools, or resources do you need in order to counter these myths and fears?

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mother's questionnaire

...continued

6 Who will be with you during the birth?

7 Who will help you after the baby is born?

8 Do you have any special requests prenatally, during the birth, or postpartum?

9 What are your plans for breastfeeding?

10 How do you feel about going to the hospital if complications arise?

11 How do you handle emotional issues in your life?

12 Have you ever experienced any form of abuse (for example, domestic violence, rape, incest, emotional abuse)?

13 Do you feel safe in your home, relationship and workplace?

14 Please feel free to share anything else you would like on the reverse of this page.

Thank you.

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WomanWise

partner's questionnaire

Name: ______________________________________

Congratulations on choosing a homebirth! It is our intention to provide you and your family with sensitive, personal care throughout the childbearing year. Many parents find that issues concerning family influences, past experiences, and present circumstances surface during the pregnancy, birth and the postpartum period. We believe that open communication and a warm and trusting midwife/client relationship are essential and therefore encourage you to give consideration in answering the following questions. The issues brought up in this form will be discussed in greater detail during your prenatal appointments as appropriate. Feel free to add any further comments or questions you may have to the end of this form. All information shared is confidential.

1 Why do you want to have this baby at home?

2 What do you see as the duties and responsibilities of your midwives?

3 What do you feel your responsibilities are regarding the pregnancy or birth?

4 What is your present understanding of complications that may occur during pregnancy or birth?

5 Our society does not always view homebirth and independent midwifery as "wise" or "safe" choices. You may find that family, friends and strangers respond to your plans to have a homebirth with comments like "but that's dangerous" and "why are you putting yourself and your baby at risk?" How would you respond to comments like these? What support, tools, or resources do you need in order to counter these myths and fears?

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WomanWise

partner's questionnaire

...continued

6 What do you see as your ideal role during the labor and birth?

7 What will your role be after the baby is born?

8 Do you have any special requests prenatally, during the birth, or postpartum?

9 What are your feelings about your partner breastfeeding?

10 How do you feel about going to the hospital if complications arise?

11 How do you handle emotional issues in your life?

12 Please feel free to share anything else you would like in the space below.

Thank you.

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nutritional profile

Name:

Date:

Please fill out the information below to help us get a general idea of your eating habits.

I usually eat	Every day	Almost every day	3-4 times a week	Once or twice a week	Almost never	Never
Breakfast						
Lunch						
Dinner						
Snacks						
Canned vegetables						
Frozen vegetables						
Fresh vegetables						
• Leafy green						
• Yellow or orange						
Fresh fruit						
Cheese or yogurt						
Eggs						
Red meat						
Fish						
Chicken						
Beans, dried peas or lentils						
Tofu or tempeh						
Nuts, peanut butter, tahini etc.						
Other sources of protein?						
Whole grains, whole wheat noodles, corn tortillas, brown rice						
White rice, spaghetti, noodles						
Items with refined sugar (candy, cake, cookies etc.)						
Soda						
Caffeinated beverages						
Milk or soymilk						
Prenatal vitamins with folic acid						
Iron supplements type:						
Calcium magnesium						

continued over...

nutritional profile

...continued.

I smoke about ________ cigarettes a day.

I drink about ________ servings of alcohol a day / week (circle one).

I smoke marijauna ________ times a day / week / month (circle one).

Please write down below what you have eaten in the past 24 hours. Be as specific as possible, stating amount and type of food (eg. "1/2 cup brown rice" instead of just "rice").