CLIENT REGISTRATION

Mother's First	Middle	Last	Maiden	Date of birth

Email	Phones Home	Work	Cell

Religion	Education: 8th grade No HS degree HS Some college,no degree Associate degree Bachelor's degree Master's degree Doctorate	Occupation

Race	State of birth	Marital Status	Have you ever been legally married? Y N	Social Security number

Street	City	Zip	County

Address is inside (circle 1): City Village Township Name:	How did you hear of me?

Father of Baby Name: First	Middle	Last	Date of birth

Race	Education: 8th grade No HS degree HS Some college,no degree Associate degree Bachelor's degree Master's degree Doctorate	State of birth	Occupation

Address, if different	Cell	Social Security number

Emergency contact: Name	Phone	Relationship

Family History— *Indicate if anyone in your immediate family has ever had any of these; who & when*

- O High blood pressure _____
- O Cancer _____
- O Diabetes _____
- O Twins _____
- O Severe emotional problems _____
- O Alcohol/drug abuse _____
- O Other _____

Father of Baby— *Has baby's father ever had:*

- O Sexually transmitted diseases _____
- O Urethritis _____
- O Herpes: genital or oral _____
- O Severe emotional problems _____
- O Alcohol/drug abuse _____
- O Tobacco use _____
- O Other _____

Your Mother's **OB history:**

# of pregnancies _____
# of live births _____
Miscarriages _____
Any complications _____
_____
Your weight at birth _____

Please answer the following questions, which will help determine if there are potential problems which should be discussed further. This information is completely confidential.

Yes No Have you or the father of the baby (FOB) every had a baby with a birth defect or mental retardation?
Yes No Do you or the FOB have any family members with birth defects or conditions diagnosed as genetic or inherited?
Yes No Are you and the FOB related by blood?
Yes No Are you or the FOB from any of these ethnic/racial groups? Jewish Black/Africa Asian Mediterranean Eskimo
Yes No Have you or the FOB ever had hepatitis or jaundice?
Yes No Have you ever used any drug intravenously or had a blood transfusion?
Yes No Have you ever had a sexual partner who used any drug IV, had a blood transfusion or had bisexual relations?
Yes No Have you had more than five sexual partners in the last five years?
Yes No Do you think you are at increased risk for having a baby with a birth defect or genetic problem?
Yes No Do you think you are at increased risk for hepatitis?
Yes No Do you think you are at increased risk for HIV/AIDS?
Yes No Have you ever experienced dramatic fluctuations in your weight?
Yes No Have you ever had anorexia, bulemia or eating problems?
Yes No Is there anything about the development of your sexuality that you'd like to discuss? _____
Yes No Have you ever been in a physically- or emotionally-abusive relationship? When? _____
Yes No Have you ever been sexually abused or made to take part in sexual activities against your will)? When? _____
Yes No Have you ever had severe emotional problems? When? _____
Yes No Have you ever been on any medication for psychological problems? _____
Yes No Has anyone ever told you, or do you think, that you have ever used alcohol or drugs excessively?

Gynecologic History

Have you ever had any of the following? List year and details

- ☐ Yeast _____
- ☐ Venereal warts (HPV) _____
- ☐ Chlamydia _____
- ☐ Cervical surgery _____
- ☐ Trichomonas _____
- ☐ Cervicitis _____
- ☐ Bacterial Vaginosis _____
- ☐ Cervical polyps or growths _____
- ☐ Gardnerella _____
- ☐ Fibroids _____
- ☐ Gonorrhea _____
- ☐ Endometriosis _____
- ☐ Syphilis _____
- ☐ Uterine surgery _____
- ☐ PID _____
- ☐ Breast lumps _____
- ☐ Genital sores _____
- ☐ Breast surgery _____
- ☐ Herpes: Oral Genital
- ☐ Abnormal bleeding _____
- ☐ Infertiility _____
- ☐ Ovarian cysts _____
- ☐ Other _____

Age at 1st period _____ Duration of flow _____ Cycle length _____ Is it regular? Y N

Date of last PAP _____ Have you ever had an abnormal PAP? _____ If so, when? _____

What was the abnormality? _____

Medical History

Have you ever had any of these? When?

- ☐ Severe headaches _____
- ☐ Eye/Vision problems _____
- ☐ Ear/hearing problems _____
- ☐ Dental problems _____
- ☐ Thyroid problems _____
- ☐ Rheumatic fever _____
- ☐ Blood clotting problems _____
- ☐ Anemia _____
- ☐ Hemorrhage _____
- ☐ High blood pressure _____
- ☐ Varicose veins _____
- ☐ Hemorrhoids _____
- ☐ Tuberculosis _____
- ☐ Asthma _____
- ☐ Allergies _____
- ☐ Stomach problems _____
- ☐ Ulcers _____
- ☐ Bowel problems _____
- ☐ Colitis _____
- ☐ Gall bladder problems _____
- ☐ Liver problems _____
- ☐ Hepatitis _____
- ☐ Diabetes _____
- ☐ Hypoglycemia _____
- ☐ Kidney infection _____
- ☐ Bladder infection _____
- ☐ Urinary surgery _____
- ☐ Urethral dilation _____
- ☐ Aching joints _____
- ☐ Pelvic/back injuries _____
- ☐ Seizures _____
- ☐ Surgeries _____

List any allergies to medications: _____

Previous Pregnancies

Indicate all pregnancies in chronological order; add separate page if needed

Date	# weeks	Birth/Miscarriage/Termination	Location	Comments

Other previous pregnancy or delivery complications:

- o Premature baby
- o Breech baby
- o Shoulder dystocia
- o overdue by more than 2 weeks
- o forceps/vacuum delivery
- o postpartum hemorrhage
- o high blood pressure
- o birth defects
- o pre-eclampsia
- o A baby considered small for it's age during pregnancy
- o a baby weighing more than 8#-13oz
- o A baby considered small for it's age at delivery
- o Significant tear involving the rectum: 3rd 4th
- o Other _____

Describe your diet:

- o Standard American diet, I eat everything and shop at regular grocery stores.
- o Vegan
- o Macrobiotic
- o I eat everything but include lots of veggies & try to buy as much organic food as possible
- o Ovo-lacto vegetarian
- o Mostly processed and fast food
- o Pesco-ovo-lacto vegetarian
- o Other _____

Do you intend to restrict your calorie intake in order to limit weight gain during pregnancy? Y N

Present Pregnancy

1st day of last menstrual flow: _____
Was it normal? _____
If not, then last normal period _____
Suspected date of conception _____
Date of Positive pregnancy test _____
Was this pregnancy planned? _____
Most recent birth control used _____
How do you feel about being pregnant?

_____

What are the partner's feelings?

_____

Have you had any of these problems during this pregnancy?

☐ Nausea
☐ Vomiting
☐ Fever
☐ Headache
☐ Dizziness
☐ Leg cramps
☐ Rash
☐ Backache
☐ Heartburn
☐ Diarrhea
☐ Urinary symptoms
☐ Abdominal pain
☐ Vaginal bleeding
☐ Vaginal discharge
☐ Bleeding gums
☐ Varicose veins
☐ Hemorrhoids
☐ Swelling
☐ Constipation
☐ Depression
☐ Family/Relationship problems
☐ Other _____

_____

Have you used or been exposed to any of the following during this pregnancy?

☐ Tobacco
☐ Alcohol
☐ Caffeine
☐ Marijuana
☐ Cocaine
☐ Street drugs
☐ Rx drugs
☐ OTC drugs
☐ Vitamins
☐ Herbs
☐ Fumes/sprays
☐ Ultrasound
☐ Measles
☐ Viruses
☐ Vaccinations
☐ Cats
☐ X-rays
☐ Other

_____

_____

_____

What are your reasons for choosing a homebirth?

Check all that apply, and state in your own words, below.

☐ safety
☐ desire for natural birth
☐ control
☐ atmosphere
☐ spiritual
☐ desire for waterbirth
☐ fear of hospitals
☐ effect on baby
☐ family unity
☐ partner preference
☐ cost
☐ social pressure

_____

_____

Have you seen another provider during this pregnancy? What type: ☐ OB/Gyn ☐ CNM ☐ Family Practice ☐ LM
☐ herbalist ☐ homeopath ☐ acupuncturist Name(s): _____

Do you see a chiropractor? Y N Name: _____ How often? _____

Have you taken or will you be taking childbirth education classes during this pregnancy? Y N What type? _____

If no, have you taken them during a previous pregnancy? Y N

Were you a smoker during the 3 months prior to this pregnancy? Y N How many per day? _____

Have you smoked during this pregnancy? Y N How many per day? _____ For how long? _____

Any alcohol use? _____ Number of drinks per week: _____ or per month: _____

Any street drugs (occasional or regular)? _____ Drug type: _____

Any medication or prescription drug use? _____ Type(s): _____

_____

Do you receive WIC benefits? Y N Are you on Medicaid? Y N Do you receive food stamp benefits? Y N

Do you plan to do perineal massage in last weeks of pregnancy? Y N Would you like more information on this? Y N

Breastfeeding is a prerequisite for out-of-hospital birth with BirthSpirit. Do you have any concerns about this? Yes No

If yes, state them here: _____

Do you plan to vaccinate your baby? Yes No Not sure, would like more information

Will you be keeping your son intact? Yes No Not sure Why or why not? _____

Do you plan to co-sleep with your baby? Yes No Not sure, would like more information

What style of parenting do you use or plan to use? _____

Who will be helping you after the baby is born? _____

Would you like a Social Security number automatically applied for with the Birth Certificate? Yes No