

PREGNANCY CONSULTATION

Due Date: _____ How many weeks pregnant are you? _____

How many pregnancies have you had? _____

How was your experience(s) _____

Do you currently have a: ___OBGYN ___Midwife ___Doula

Are you aware of the different benefits that these birthing professional provide? ___YES ___NO

Would you like us to help you find the right one for you and your needs? ___YES ___NO

Do you currently have a birthing plan? ___YES ___NO

Would you like some assistance to write one? ___YES ___NO

Are/will you be attending a prenatal class with or without your spouse? ___YES ___NO

Do you currently participate in a prenatal exercising/ yoga program ? ___YES ___NO

Are you taking dietary supplements ? ___YES ___NO

If so, which ones? _____

Describe your sleeping patterns (ex:# hours, position, intermittent or through the night)

From your previously listed Health Concerns:

Which ones have been since becoming pregnant?

Have the previous Health Concerns been made worse by the pregnancy? ___YES ___NO

Do you have fears and concerns with your pregnancy and/or delivery and/or parenting ?

Please explain: _____

Do you have question regarding: (check all that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> antibiotics | <input type="checkbox"/> exercising | <input type="checkbox"/> parenting |
| <input type="checkbox"/> breast feeding | <input type="checkbox"/> fevers | <input type="checkbox"/> sleeping positions |
| <input type="checkbox"/> birth trauma | <input type="checkbox"/> formula | <input type="checkbox"/> ultrasounds |
| <input type="checkbox"/> breech baby | <input type="checkbox"/> genetic diseases | <input type="checkbox"/> vaccination/shots |
| <input type="checkbox"/> community resources | <input type="checkbox"/> illness | <input type="checkbox"/> VBAC |
| <input type="checkbox"/> childhood development | <input type="checkbox"/> home birth | <input type="checkbox"/> water birth |
| <input type="checkbox"/> chiropractic care | <input type="checkbox"/> massage | <input type="checkbox"/> work position |
| <input type="checkbox"/> delivery positions | <input type="checkbox"/> medications | <input type="checkbox"/> your rights as a woman/
mother birthing |
| <input type="checkbox"/> due date suggestions | <input type="checkbox"/> medical interventions | <input type="checkbox"/> yoga |
| <input type="checkbox"/> diet/supplementation | <input type="checkbox"/> multiple babies | |
| <input type="checkbox"/> dystocia | <input type="checkbox"/> postpartum | |