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Description automatically generated

**Postpartum Doula Services Intake Form**

**Client Information**  
Name(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Preferred Contact Method: ☐ Phone ☐ Email ☐ Text

**Expected Due Date or Baby’s Birth Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Birth Location: ☐ Home ☐ Birth Center ☐ Hospital (Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)  
Baby’s Name (if known): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Gender (if known): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Type of Birth: ☐ Vaginal ☐ Cesarean ☐ Planned ☐ Unplanned

**Family Information**

Partner’s Name (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Siblings (names and ages): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Other adults living in the home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Pets: ☐ Yes ☐ No — Type(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Support Needs**

Please check any areas where you would like support:

☐ Newborn care education  
☐ Feeding support: ☐ Breastfeeding ☐ Bottle-feeding ☐ Pumping  
☐ Infant soothing techniques  
☐ Sleep and routine support  
☐ Light housekeeping (laundry, dishes, tidying)  
☐ Meal or snack preparation  
☐ Emotional support/check-ins  
☐ Partner or sibling adjustment  
☐ Resources and referrals (lactation, mental health, etc.)  
☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your main concerns or priorities for postpartum support?

**Health & Recovery**

How are you feeling physically and emotionally since giving birth?

Any complications during birth or postpartum recovery that your doula should be aware of?  
☐ Yes ☐ No — If yes, please explain:

Do you have a history of:  
☐ Postpartum depression/anxiety  
☐ Other mental health concerns  
☐ None  
If checked, are you currently receiving professional support? ☐ Yes ☐ No

**Feeding Plan**

How are you currently feeding your baby?  
☐ Breastfeeding ☐ Bottle-feeding ☐ Combination ☐ Formula ☐ Pumping

Any specific challenges or goals with feeding?

**Household Preferences**

Are there any cultural, dietary, or religious practices you would like the doula to be mindful of?

Are there household tasks you **do not** want the doula to assist with?

Any allergies (baby, parent, or household)?

**Scheduling & Availability**

Preferred start date for doula services: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Preferred days/times for visits: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Do you anticipate needing:  
☐ Daytime support  
☐ On-call/emergency availability  
☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Anything Else You’d Like to Share?**

**Signature of Client:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reviewed by Doula:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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