



Data Collection

Post-Natal Form

Please check boxes accordingly and write an explanation next to "other" when applicable in provided spaces. Your signature implies to the best of your knowledge, you supplied accurate information.

Participant Information

Name: _____

DOB: _____

Pregnancy #: _____

Birth #: _____

Doula Information:

Name: _____

Labor Hours: _____

Zip Code: _____

Doula Matched Client Cultural Identity? Y/N

Program Type (if any):

Is Participant an
Immigrant? Y / N

Ethnicity: _____

Primary Caregiver:

- OBGYN (MD)
- Family Practice (MD)
- Midwife (CPM/CNM)
- Combination

Place of Birth:

- Home
- Hospital
- Birth Center

Present at Birth:

- Partner
- Doula
- Others:

Pregnancy:

- Normal
- Hypertension
- High Risk
- ECV
- Gestational Diabetes
- Breech > 32 Weeks
- Post > 42 Weeks
- Prem. < 38 Weeks
- Multiples
- Other:

Medications:

- None
- Epidural < 5cm
- Epidural > 5cm
- IV Pain Medications
- Nitrous Oxide
- Other:

Interventions:

- None
- Induction
- Pitocin
- Artificial Rupture of Membranes
- Doppler Auscultation
- Electric Fetal Monitoring
- Continuous
- Intermittent
- Both
- Fetal Scalp Electrode
- Intrauterine Pressure Catheter
- Other:

Method of Birth:

- Natural / Vaginal
- Planned Cesarean Birth
- Forceps / Vacuum
- Unplanned Cesarean Birth
- Vaginal Birth After Cesarean
- Repeat Cesarean

Childbirth Education Classes: Y / N

Wellness Services:

- Yoga
- Chiropractor
- Acupuncture
- Other:

Infant Birth Outcome:

- Normal
- Premature
- Stillbirth
- Birth Defect:
- Intensive Care:
- Other:

Infant Birth Weight: __ lbs __ oz

Infant Birth Length: _____

APGAR: ___ 1min ___ 2min

Breastfeeding: Y / N

Immediate Skin-to-Skin: Y / N

Infant with Birthing Parent:

- For < 30 Min after birth
- For > 30 Min after birth

Labor Length (hours): _____

Time/Date

Admitted: _____

Time/Date of Birth: _____

Time/Date Discharged: _____