



Client Intake Sheet

All sections must be filled in for us to process your intake form.

Name: As it appears on your health card or government issued ID		EDD(Estimated Due Date): YEAR/MM/DD	
Email address:		Do you have an Ontario Health Card (OHIP)? <input type="checkbox"/> yes <input type="checkbox"/> no	
Phone number: (where a message can be left)		First day of last period: YEAR/MM/DD	
Address: Including City and Postal Code		Are your periods regular? <input type="checkbox"/> yes <input type="checkbox"/> no Length of cycle (ie 28 days):	
Language:		Do you require an interpreter?	
Medical & Obstetric History	Pre-pregnancy weight: Specify pounds or Kgs	Height:	BMI:
	Date of birth: YEAR/MM/DD		
	Past or Present Medical Conditions: Please check all that apply. <input type="checkbox"/> Major health conditions or surgeries requiring specialist involvement or medications <input type="checkbox"/> Diabetes <input type="checkbox"/> Lung problems <input type="checkbox"/> High blood pressure <input type="checkbox"/> Heart issues <input type="checkbox"/> Epilepsy <input type="checkbox"/> Kidney disease <input type="checkbox"/> Blood clotting issues <input type="checkbox"/> Mental health issues Provide details of anything that you have checked off: <input type="checkbox"/> None of the above		
	Please list all medications you are currently taking and for what purpose:		
	How many times have you been pregnant including this pregnancy?		
	Please provide details of your previous pregnancies and deliveries including any complications: (ie: preterm delivery, induction of labour, forceps, vacuum, caesarean or delivery complications)		
	Pregnancy/Delivery Date	Describe	
Have you had a midwife before? <input type="checkbox"/> yes <input type="checkbox"/> no		Have you delivered at home before? <input type="checkbox"/> yes <input type="checkbox"/> no	
Are you a repeat Blue Heron Midwives client? <input type="checkbox"/> yes <input type="checkbox"/> no		Where would you like to deliver: <input type="checkbox"/> Home <input type="checkbox"/> Grand River Hospital <input type="checkbox"/> Undecided	
Have you had prenatal care yet this pregnancy? <input type="checkbox"/> OB <input type="checkbox"/> Family Doctor <input type="checkbox"/> Midwife <input type="checkbox"/> No care yet			
Family Doctor/OB: Phone Number:		Have you had any of the following done in this pregnancy? Blood Work <input type="checkbox"/> yes <input type="checkbox"/> no Ultrasound <input type="checkbox"/> yes <input type="checkbox"/> no	
It is our policy that clients wear a mask for all appointments. Do you agree to this policy? <input type="checkbox"/> yes <input type="checkbox"/> no			

The Ministry of Health and Long-Term Care collects data on those who seek midwifery services. Do we have your consent to forward your Name, Date of Birth, and Postal Code to the MOH for this purpose? yes no

If you come into our care, would you like your name added to our contact list? yes no

Are you interested in learning more about free Breastfeeding Buddies resources? yes no

Midwives are primary care providers who specialize in low-risk pregnancy and birth. In Ontario, you can choose to have a midwife or a doctor (OB/FP) look after you when you're pregnant, but not both. Please acknowledge that you are choosing midwifery care: yes no