Womb Surround Process Workshop ADULT INTAKE FORM:

Thank you for taking the time to provide this information. Please use additional pieces of paper if necessary, and attach them to this form.

Name:_____ Date_____

Address:

_____

_____

Phones:
Home: _____ Cell: _____

Email: _____

D.O.B.: _____ Age:_____ Profession/past profession: _____

_____Licenses & degrees:

_____

What is your intention for doing this work?

Do you have any medical conditions that would exclude you from physical activity in a session?
Yes _____ No _____ Please explain:

Height _____ Weight _____

Do you have any areas of your body that need special consideration?

Are you presently taking any medications or drugs? (name of medication, for what condition):

Are you presently using any recreational drugs, alcohol or nicotine? (amount per day/week):

What psychological or bodywork training have you had?

What kinds of psychological or bodywork therapy have you experienced, and for what period of time?

Name _____

Are you in therapy or having regular bodywork? If yes, with whom?

Does this person have pre and peri-natal facilitation skills? Yes _____ No ___

List other physicians or health care practitioners you are being treated by:

List any other support you have:

Please check what you know or think applies to your birth history:

_____ an unmedicated vaginal birth in a hospital
_____ an unmedicated vaginal birth at home
_____ an anesthesia birth
_____ c-section
_____ a multiple birth
_____ other birth complications, please explain:

_____ with fetal heart monitor
_____ with cranial suction
_____ with forceps
_____ breech

Please check what you know or think applies to your prenatal and birth history:

_____ I had a twin that did not live. At what point in the pregnancy or postnatal time did the twin leave? _____
_____ I was premature. How many weeks? _____
_____ I was in Neonatal Intensive Care Unit, Please state how long _____
_____ I was incubated. How long? _____

Where was your father during the birth?

Were you separated from your mother after birth? (sent to nursery)?

Were you breast fed?_____ if yes, how long? _____

Men, were you circumcised as an infant? _____

Please tell me about any interventions shortly after your birth such as hospitalization for illness or high jaundice, operations, illnesses as an infant or child.

Name _____

Did either or both of your parents lose another child to miscarriage, abortion, stillbirth, or childhood death? If yes, are you aware of how this affected you? Give dates and circumstances:

Who raised you? Were your parents your natural parents? Where you raised by a single parent? If your parents split up, how old were you? Did you have other major primary care givers like grandparents, aunts, uncles, guardians or adoptive parents?

Do you or did you have siblings? Indicate ages relative to you, nature of relationship as children:

Please tell me any other information you know concerning your conception, your parents' attitude toward having you (planned, unplanned, wanted, confused, unwanted).

What do you know about your life in the womb, including physical effects (maternal or paternal smoking, drinking, drugs, mom's diet), and emotional effects including absence or presence of father during pregnancy or birth, parents' relationship with each other during your pregnancy, siblings' attitude toward your birth. If you are adopted, give information about transition in hospital and new family, as well as any birth history known:

Name _____

Have you ever lost a child to miscarriage, abortion, stillbirth, death? Yes ____ No ____
If yes, please explain circumstances and dates and how this affects you today:

Have you ever been or are you in an abusive relationship? Yes ____ No ____
If yes, please state when, what relation the person was or is to you, whether the abuse was or is physical, sexual or emotional. If a past relationship, what action did you take? If present, what are you doing about it? Please give details:

Have you, or anyone in your family of origin, been diagnosed with mental health issues, e.g. bipolar, schizophrenia, depression, etc? Yes ___ No ___ If yes, please explain:

Have you or anyone in your family taken prescribed medications for mental health issues? Yes ___ No ___ If yes, please explain:

Have you ever been hospitalized for mental health reasons? Yes ____ No ____
If yes, please describe the circumstances and outcomes with dates:

Has anyone in your family ever attempted or committed suicide? Yes ____ No ____
Have you ever contemplated or attempted suicide? Yes ____ No ____
If yes, please describe the circumstances with dates:

Do you have children? Yes ____ No ____ If Yes, state their ages and your experience of their gestation and birth:

Name _____

I agree to the following: (Please initial each and sign at the bottom)

_____ I take responsibility for my well being during and after the workshop.

_____ I am in good physical, emotional and mental condition and can participate in the regularly scheduled activities of the workshop.

_____ I understand that all the shared material that I learn from other participants in the workshop is totally confidential.

_____ I agree to abstain from alcohol and recreational drugs the day before the workshop until the completion of the workshop including breaks and evenings.

_____I agree to attend all scheduled days, arriving on time and leaving when the workshop is complete.

I have access to follow up professional support after this workshop?

Yes_____ No_____ If yes, with whom?_____ Does this person have pre and perinatal facilitation skills? Yes_____ No_____. In addition to your own community professionals, Kate and Maggie are available for Skype sessions following the workshop.

If you do not have access to follow up therapy, what do you plan to do to support yourself after this workshop?

Signature_____ Date:_____