WOMB PROCESS WORKSHOP – INTAKE FORM

Name:_________________________________ Date: ___________________

D.O.B.:______________Age________ Profession________________________
Address:
____________________________City_______________State___Zip_______

Phone:(home) ____________________ (work) _________________________

(cell) _______________________ Email: _____________________________

Who recommended this work to you? _____________________

Family/relationships [married / partnered (how long?), children, grandchildren (age, sex)]:

• If you are a bodyworker, psychotherapist or health care practitioner or student of these, indicate nature of your practice or extent of training. (types of therapy, clients /week)

• What is your purpose for taking this workshop?

• Some of the workshop techniques involve physical exertion. Do you have any medical conditions that would contraindicate involvement in such techniques? Yes No
If yes, please explain.

• Height_____. Weight______. Do you have any area of your body that needs special consideration?

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

NAME _________________________________

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

• I have access to follow up therapy after this workshop? Yes No
If yes, with whom?

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

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

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

• Please initial the following:
_____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 from other participants in this workshop is confidential.

Please check what you know or think applies to your birth history. My birth was:
__ an unmedicated vaginal birth in a hospital
__ an unmedicated vaginal birth at home
__ an anesthesia birth
__ with forceps
__ with cranial suction
__ with fetal heart monitor
__ c-section
__ breech
__ a multiple birth
__ other birth complications, please explain (use extra pieces of paper if neccessary).

Signature:___________________________________ Date:______________

NAME ______________________________

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 post natal time did the twin leave?
__ I was premature. How many weeks?
__ I was in a Neonatal Intensive Care Unit. Please state how long.
__ I was incubated. How long?

Where was your father during your birth?

Were you separated from you mother at birth (sent to a nursery)?

Were you breast fed?____ If yes, how long?____

Men, were you circumcised as an infant?_____.

Please note any interventions shortly after birth such as hospitalization for illness or high jaundice, operations, illnesses as an infant or a child.

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, aunt and uncles, guardians or adoptive parents?

NAME ______________________________

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

Please relate any other information you know concerning your conception, your parents' attitude toward having you (planned, unplanned, wanted, confused, nwanted). If unwanted, did they consider or attempt abortion?

NAME ________________________________

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.

Have you ever lost a child to miscarriage, abortion, stillbirth or 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 and or emotional. If a past relationship, what action did you take? If present, what are you doing about it. Please give details.

NAME ________________________________

Have you ever been prescribed medications for mental health reason? Yes___No___
If yes, please describe the circumstances and outcomes with dates.

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.

Please initial the following, I agree to:

_____ Attending all 2 or 3 days, arriving on time in the morning and after lunch breaks and leaving at the end of the day after the workshop is complete. If flying in, I will plan to arrive at least two hours early in case of airline delays.
_____Abstaining from alchohol, recreational drugs and nicotine from the day before the workshop until the completion of the workshop including breaks and evenings.
_____Not using perfume or aromatherapy or strongly scented shampoos.
_____Maintaining confidentiality about what takes place in the workshop.

____ ___________
Signature Date