



End-of-Life Doula Services

Client Intake Form

CLIENT'S INFORMATION:

Name: _____ Date: _____

Address: _____

Phone No.: _____ Email: _____

City: _____ State: _____ Zip: _____

Emergency Contact: _____ Phone No.: _____

EMERGENCY CONTACT

Name: _____ Date: _____

Address: _____

Phone No.: _____ Email: _____

HEALTH INFORMATION:

Primary Care Physician: _____ Phone No.: _____

Specialist(s) Involved in Care: _____

How do you currently manage pain? Please describe any medications, therapies, or techniques you use:

Do you use any mobility aids, such as a wheelchair or walker? If yes, please specify:

Allergies Checklist:

Medication Allergies:

- Penicillin
- Sulfa drugs (sulfonamides)
- Aspirin
- NSAIDs
- Others: _____

Food Allergies:

- Nuts
- Shellfish
- Dairy products
- Eggs
- Wheat or gluten
- Soy
- Others: _____

Environmental Allergies:

- Pollen
- Dust mites
- Pet dander
- Mold
- Insect stings
- Latex
- Others: _____

Have you had chemotherapy/radiation within the last 6 months? No Yes:

If yes, please explain: _____

Any previous surgeries, including plastic surgery? No Yes:

If yes, please explain: _____

Medications and Supplements:

Check the box if you are taking any of the following

- | | |
|---|--|
| <input type="checkbox"/> Prenatal vitamins | <input type="checkbox"/> Antacids |
| <input type="checkbox"/> Iron supplements | <input type="checkbox"/> Pain relievers |
| <input type="checkbox"/> Folic acid supplements | <input type="checkbox"/> Insulin |
| <input type="checkbox"/> Calcium supplements | <input type="checkbox"/> Thyroid medications |
| <input type="checkbox"/> Progesterone | <input type="checkbox"/> Antibiotics |

Are you taking any other drugs? No Yes:

If yes, please explain: _____

Are you currently receiving medical treatment? No Yes:

If yes, please explain: _____

EMOTIONAL REQUIREMENTS:

I aim to create a safe space where you feel heard and supported. Please share any emotional concerns, anxieties, or goals you have related to this journey, so that I can better understand how to support you:

Emotional Concerns or Anxieties: _____

Any special care for mental health problems: _____

Medical Conditions

- | | |
|--|---|
| <input type="checkbox"/> Hypertension (High Blood Pressure) | <input type="checkbox"/> Heart Conditions |
| <input type="checkbox"/> Gestational Diabetes | <input type="checkbox"/> History of Preterm Birth |
| <input type="checkbox"/> Thyroid Disorders (e.g., Hypothyroidism) | <input type="checkbox"/> History of Miscarriage |
| <input type="checkbox"/> Anemia (Iron-Deficiency) | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Autoimmune Disorders (e.g., Lupus) |
| <input type="checkbox"/> Preeclampsia | <input type="checkbox"/> Depression or Anxiety |
| <input type="checkbox"/> Polyendocrine Metabolic Ovarian Syndrome (PMOS) | <input type="checkbox"/> Substance Use Disorder (if applicable) |
| <input type="checkbox"/> Multiple Gestation (e.g., Twins or Triplets) | <input type="checkbox"/> Other: _____ |

PREFERENCES:

Please share your preferences regarding the care and attention you expect from your end-of-life doula.

Preferred Location for End-of-Life Care: _____

Advance Care Planning in Place:

Advance
Directive

Medical Power of
Attorney

Do Not Resuscitate
Order

End-of-Life Wishes or Preferences: _____

Any Cultural or Religious Preferences: _____

Cultural or Personal Rituals or Traditions to be Honored: _____

LEGACY AND LIFE REVIEW:

Would you be interested in reflecting on your life story and accomplishments?

Do you have any preferred legacy projects or activities you would like to pursue? (Examples include writing letters to loved ones, recording memories, creating keepsakes, etc.)

What are your goals for your legacy work? How would you like to be remembered by your loved ones and future generations?

GRIEF AND BEREAVEMENT SUPPORT:

How do you currently cope with grief and loss?

Are there any specific aspects of grief or bereavement that you would like support with?

Do you have any preferences for how you would like to receive grief and bereavement support (e.g., individual counseling, support groups, spiritual guidance)?

Acknowledgement

By signing below, I acknowledge that the information provided is accurate and complete to the best of my knowledge.

Signature

Date