Your Village Consulting

Prenatal Overnight Sleep Intake Form

Name: _____ **Address: _____**
Email: _____ **Cell #: _____**
Baby's name_____
Baby's DOB: _____ **Home #_____**

Partner's Name: _____ **Partners Cell #: _____**

Are you taking time off from work and if yes, how long? _____
Will you partner be taking off time from work and if yes, how long? _____
Do you have any other adults living in your household? _____
Please tell us the names and ages of any other children you have: _____
Was your baby born early, on time, or late?_____
Were there any medical complications at birth for baby or mother?_____
_____
Are there any pets in your home and if yes, what kind? _____
Are you planning to breast or bottle feed or undecided? _____

What parenting books have you read? _____
Are there any parenting techniques you plan to use? _____
_____

What is your primary goal in having overnight sleep support? _____
_____

<u>Sleep</u>

Do you plan on having your baby sleep in your room? If yes, where do you want your child to eventually sleep?

Are you comfortable with any crying? If yes, how much? If no, that's okay too.

Anything that you and your spouse/partner differ on when it comes to the infant and sleep?

What kind of overnight support is most essential when hiring someone (i.e. assistance with baby laundry, helping with sleep training, help learning how to take care of a newborn, breastfeeding help, etc)?

Do you know about how many nights/week and total weeks you would like support? If so, how many?

Additional Information

Any other children in the home? Ages? What are their sleep patterns like?

Will you have additional help (other family members, nanny, babysitters, etc) once the baby arrives?

Was there a book or approach you had hoped to utilize with your child?

What is your ultimate goal in this process?

Anything else that you think is relevant or helpful?