REGISTRATION FORM

Please complete and bring to first class.
Please bring 2 pillows to each class.

Mother's Name ____ Age ____________

Partner's Name ____ Age ____________

Address ____________________________ City __________________ Zip ____________

Home Phone _________________________ Work phone ____________________________

Doctor _____________________________ Due Date ___/___/____ Number of Children ______

If you have other children, please list names, ages, and method of delivery ____________________

____

Mother's Occupation ______________________ Partner's Occupation ______________________

Please list any physical limitations you or your partner have which might affect your participation in class exercises ____

Have you had any problems or concerns with this or any previous pregnancy? ________________

____

What are you and your partner's concerns about:

1. Labor and birth: ____

   ____

2. Your needs after the baby is born: ____

   ____

3. Caring for your new baby: ____

   ____

How do you plan to feed your baby? _____ breast _____ bottle _____ undecided

What is it that you and your partner want from this class? __________________________

____

Is there anything that you could tell us about you or your partner that would help us to meet your needs in class? ____

What is it that you and your partner want from your birth experience? ____________________

____

Did your Healthcare Provider encourage you to take this class? ________________________

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