Lydia Robinson, RN, CD(DONA), IBCLC
www.laboredwithlove.com

MENTORSHIP INTAKE FORM

CONTACT INFORMATION

Mentee

Name_____DOB_____Occupation_____

Address_____

Phone (Cell)_____(Other)_____

Email Address_____

Emergency Contact

Name_____Relationship_____

Phone (Cell)_____(Other)_____

Email Address _____

HEALTH HISTORY

List any significant medical history (Asthma, diabetes, lupus, etc):

_____

_____

List all medications/herbal supplements:_____

_____

Drug Allergies/Reactions:_____

Do you Drink alcohol? _____ If yes, how often and how much?_____

Do you use illicit/street drugs?_____ If yes, list and how often?_____

TRAINING & EXPERIENCE

Organization_____Trainer_____Phone_____

Dates of Workshop_____ Location_____

Are you certified?_____ Do you plan to certify?_____

Have you taken Childbirth Education Classes? _____ If yes, location & instructor _____

Have you taken a Breastfeeding Class?_____ If yes, location & instructor_____

Other classes/trainings taken in preparation:

_____

_____

Describe your experience as it relates to the perinatal field:

_____
_____
_____
_____

Are you an established doula/birth worker already taking clients?_____

If yes, describe your current business structure or client work load:

_____
_____

ABOUT YOU

What is your current confidence level in working with clients (0-none 10-most)? Explain.

_____

_____

What are your main goals in completing this program?

_____

_____
_____
_____

Are there any specific topics you would like to cover?

_____
_____

Describe your desired client population_____

_____
_____

What are your expectations for you Mentor's role during this process? _____

_____

What else would you like me to know about your history, hopes, dreams, fears, strengths, or limitations?_____

_____
_____
_____
_____

What is your vision for your professional practice?

_____
_____