Existing Client Intake Form

Erica Lötter · Certified Baby Sleep Consultant
072 616 2451 · erica@momslifeline.co.za · momslifeline.co.za

How to complete this form: please write clearly in pen and answer as accurately as you can — the more detail you give, the more personalised your sleep plan. Fields marked * are required. Tick the boxes that apply. When you're done, email a scan or clear photos to **erica@momslifeline.co.za**, WhatsApp them to **072 616 2451**, or hand it to Erica. You can also complete this form online at **momslifeline.co.za/intake-forms**.

1 Invoice details

So we can match this form to your existing file.

Invoice number

2 Mother's details

Please complete as accurately as possible.

Mother First Name *

Mother Surname *

Mother ID Number

Mother Occupation

Physical Address

Email Address *

Telephone Number

Mobile Number *

3 Father's details

Where applicable. Leave blank if not applicable.

Father First Name

Father Surname

Father ID Number

Father Occupation

Physical Address Father

Email Address

Telephone Number

Mobile Number

4 Account & package

This helps us prepare the correct quotation.

Who will be responsible for paying the account? (Tick one)

- ☐ Mother
- ☐ Father
- ☐ Both parents / joint
- ☐ Medical aid
- ☐ Other / third party

How will the account be paid? (Tick one)

- ☐ EFT / bank transfer
- ☐ Card payment (Yoco)
- ☐ Cash
- ☐ Medical aid
- ☐ To be discussed

Please choose a support package * (Tick one)

- ☐ Online Consultation
- ☐ One on One Consultation
- ☐ Day Sleep Training
- ☐ Night Sleep Training (Per Night)
- ☐ Sleep training package (2 Nights)
- ☐ Night Nanny training
- ☐ Expectant parent training
- ☐ WhatsApp or email support
- ☐ Gift voucher
- ☐ Not sure yet — please advise

Promo code (if you have one)

How many children are you completing this form for?

5 Your child's details

The more detail you give here, the more personalised the plan.

Child's full name *

Date of birth *

Current weight

Gender (Tick one)

- ☐ Girl
- ☐ Boy
- ☐ Prefer not to say

Have you previously completed the Momslifeline Sleep Training Programme?

- ☐ Yes
- ☐ No

If yes, please tell us a little more:

Does your child have any allergies?

☐ Yes ☐ No

If yes, please explain:

Does your child have any special needs or take any medication?

☐ Yes ☐ No

If yes, please provide details:

What time does your child usually go to bed?

How does your child usually fall asleep? (Tick all that apply)

☐ Movement ☐ Feeding ☐ Contact Nap ☐ Other

If other, please explain:

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6 Night wakings

Give the approximate time and what happens when your child wakes.

How many times does your child usually wake up at night?

☐ My child doesn't wake up at night ☐ 1 time ☐ 2 times

☐ 3 times ☐ 4 times ☐ 5 or more times

For each wake-up: roughly what time, and what happens? (e.g. needs milk, a nappy change, rocking, walking to your room)

	Wakes at	What happens when your child wakes?
Wake Up 1		
Wake Up 2		
Wake Up 3		
Wake Up 4		
Wake Up 5		

Do you have a nanny or night nurse?

☐ Yes ☐ No

If yes, please describe their shift schedule and involvement — which days and hours they work, and what they do (e.g. night feeds, settling, nappy changes).

How many feeds does your child currently have during the night?

What does your child normally wear to sleep? (Tick all that apply)

- ☐ Baby grow and blankets
- ☐ Pajamas
- ☐ Sleep sack
- ☐ Swaddle
- ☐ Loose blankets or duvet
- ☐ Other

Where does your child sleep? (Tick all that apply)

- ☐ Own room – crib
- ☐ Own room – bed
- ☐ Shares a room with siblings
- ☐ Shares a room with parents
- ☐ Bedshares with parents

Does your child use a pacifier to sleep? (Tick all that apply)

- ☐ Yes, and I often have to put it back in
- ☐ Yes, but my child can put it back in independently
- ☐ No, my child does not use a pacifier
- ☐ Only during sleep
- ☐ Other

If other, please explain:

7 Progress since your last consultation

What has changed and what you still need help with.

Have you implemented any of the advice given during your previous consultation?

☐ Yes ☐ No

If yes, please explain:

What sleep training or changes have you tried since your last consultation?

What results have you seen?

Please describe what has happened since your last consultation and what you currently need help with.

Does your child use any other sleep props or objects to fall asleep?

☐ Yes ☐ No

If yes, please explain:

Does your child use delaying tactics at bedtime?

☐ Yes ☐ No

If yes, please explain:

8 Confirmation & consent

Please read, tick and sign. Required.

☐ I confirm that I have read and understood the Momslifeline Terms & Conditions (momslifeline.co.za/terms-conditions). I consent to Momslifeline processing my personal information and my child's information for the purpose of providing personalised sleep support, in accordance with POPIA. *

By signing you also confirm that:

- I understand that Momslifeline provides educational sleep consultancy and that this does not replace medical advice, diagnosis or treatment.
- I understand that I remain responsible for decisions regarding my child's care, health, safety and sleep environment.
- I agree not to copy, distribute or share personalised sleep programmes or materials without written permission.

Full name

Signature

Date

Office use: Received ____ / ____ / _____ Reference: MLL-_____ Captured: ☐

+ Additional child (if applicable)

Completing this form for more than one child? Fill in this page for each additional child (copy it if you need more).

Child's full name *

Date of birth *

Current weight

Gender (Tick one)

☐ Girl ☐ Boy ☐ Prefer not to say

Have you previously completed the Momslifeline Sleep Training Programme?

☐ Yes ☐ No

If yes, please tell us a little more:

Does your child have any allergies?

☐ Yes ☐ No

If yes, please explain:

Does your child have any special needs or take any medication?

☐ Yes ☐ No

If yes, please provide details:

What time does your child usually go to bed?

How does your child usually fall asleep? (Tick all that apply)

☐ Movement ☐ Feeding ☐ Contact Nap ☐ Other

If other, please explain: