New Client Intake Form

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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 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

Cellphone Number *

2 Father's details

Where applicable. Leave blank if not applicable.

Father First Name

Father Surname

Father ID Number

Father Occupation

Physical Address

Email Address

Telephone Number

Cellphone Number

3 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?

4 Your child's details

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

Name of the child *

Date of birth *

Current weight of child

Birth weight

Gender (Tick one)

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

Have you previously tried any sleep programmes or sleep-training methods with your child?

- ☐ Yes
- ☐ No

If yes, please explain:

Is your child currently eating solid foods?

- ☐ Yes
- ☐ No

If yes, please provide some examples of the foods your child eats.

Does your child have any allergies?

☐ Yes ☐ No

Allergies of child:

Does your child have any special needs?

☐ Yes ☐ No

If yes, please provide details.

Is your child currently taking any medication or supplements?

☐ Yes ☐ No

If yes, please list them.

5 Daily routine & sleep associations

Describe a typical day and night as it currently is.

What time does your child usually start their day?

What time does your child usually go to bed?

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

☐ Movement ☐ Feeding ☐ Contact / being held ☐ Other

If other, please explain:

Daytime naps (leave any naps your child doesn't have empty)

	Starts	Ends	Length
Nap 1			
Nap 2			
Nap 3			
Nap 4			
Total daytime sleep			

Are your child's daytime naps inconsistent?

☐ Yes ☐ No

If you selected "Yes", please tell us more.

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

☐ Movement ☐ Feeding ☐ Contact / being held ☐ Other

If other, please explain:

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?
Night Wake-Up 1		
Night Wake-Up 2		
Night Wake-Up 3		
Night Wake-Up 4		
Night Wake-Up 5		

Are your child's night wakings inconsistent?

- [ ] Yes
- [ ] No

If you selected "Yes", please tell us more.

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)

- [ ] Babygrow and blankets
- [ ] Pajamas
- [ ] Sleep sack
- [ ] Swaddle
- [ ] Loose blankets or duvet

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

- [ ] Own room in a crib
- [ ] Own room in a 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)

- [ ] No, my child does not use a pacifier.
- [ ] Yes, only for sleep.
- [ ] Yes, I often have to reinsert it.
- [ ] Yes, my child can put it back in themselves.
- [ ] Other

If other, please explain:

7 Sleep props & settling

What your child relies on to fall asleep.

Does your child use any other sleep props to fall asleep? (Tick all that apply)

- [ ] Nursing to sleep
- [ ] Bottle to sleep
- [ ] Rocking to sleep
- [ ] Bouncing, swaying, or any other movement
- [ ] My baby falls asleep independently during day or night
- [ ] Other, please specify

If other, please explain:

Which personality traits best describe your child? (Tick all that apply)

- [ ] Quiet, mellow and laid-back; generally does not mind change.
- [ ] Cranky or fussy; rarely in a happy mood.
- [ ] Clingy or anxious; often experiences separation anxiety.
- [ ] Strong-willed or stubborn; tends to resist change.
- [ ] Happy and playful; usually in great spirits.
- [ ] Other

If other, please explain:

Please tell us anything else about your child's personality that you feel is important.

Does your child use delaying tactics at bedtime?

- [ ] Yes
- [ ] No

If yes, please explain.

Which statement best describes how you feel about hearing your child cry? (Tick all that apply)

- [ ] I don't mind hearing crying.
- [ ] I don't mind hearing some crying.
- [ ] I cannot hear my child cry at all.
- [ ] Other

If other, please explain:

How is your child currently getting their nutrition? (Tick all that apply)

- [ ] Breastfeeding
- [ ] Formula
- [ ] Solids
- [ ] Other

8 Birth & medical background

This helps us rule out physical causes before changing routines.

How would you describe your pregnancy? (Tick one)

- ☐ Easy
- ☐ Baby was in distress
- ☐ Other
- ☐ Emotionally difficult for Mom
- ☐ Mom and baby were in distress

If other, please explain:

1st APGAR score (out of 10)

2nd APGAR score (out of 10)

If you know the details, please provide any relevant information about the APGAR scores.

Were you iron deficient during or after your pregnancy?

☐ Yes ☐ No

If yes, please provide any relevant details.

Please provide any additional information or specific questions that will help us better assist you.

How did you hear about Momslifeline? (Tick one)

- ☐ Word of mouth
- ☐ Website
- ☐ Facebook
- ☐ Physician / healthcare professional
- ☐ Instagram
- ☐ Other

If other, please explain:

9 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).

Name of the child *

Date of birth *

Current weight of child

Birth weight

Gender (Tick one)

☐ Girl ☐ Boy ☐ Prefer not to say

Have you previously tried any sleep programmes or sleep-training methods with your child?

☐ Yes ☐ No

If yes, please explain:

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