FTM

WAYFARING BABY WEARING CONSULTANCY INTAKE FORM:

Name: Birthday: Due Date (if any):
Kids Names/Ages (if any):
Email:
Address: City: State:

What are your Goals with baby wearing?

Tell me about your current experience with wearing baby/babies? What carriers styles have you worked with?

What specific carrier are you needing help with or have questions about?

Do you have any pain/injuries/mobility issues?:

Can you think of any time when you wished you had your baby carrier? Or a time when are you wishing you were wearing the carrier? If so, tell me about it:

Where are you storing the carrier? / Is it easy for you to access when it could come in handy?:

Please list some dates/times you are available for a consultation: