

PRENATAL INTAKE FORM

Full Name: _____ Date: _____ File # _____

Address: _____

Phone number: _____ Email: _____

Would you like text or email appointment reminders? YES/ NO (circle one)

Marital Status: Single / Married / Widowed DOB: _____

Emergency contact: _____ Emergency contact

phone number: _____ Relation? _____

Whom may we thank for referring you? _____

Week of Pregnancy _____ Due Date _____ Sex: Male / Female / Unknown

Name of Obstetrician/Midwife: _____

Name of the Practice: _____

Address of the Practice: _____

May we contact them? YES / NO (circle one)

Name of Doula: _____ Name of the practice: _____

May we contact them? YES / NO (circle one)

Please check if any of these pertain to you:

- | | |
|---|--|
| <input type="checkbox"/> Over the age of 36 | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> First Pregnancy | <input type="checkbox"/> Indigestion |
| <input type="checkbox"/> Pregnant with Multiples | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Morning sickness, vomiting, nausea | <input type="checkbox"/> Breech/Transverse |
| <input type="checkbox"/> Gestational Diabetes | <input type="checkbox"/> Leg Cramps/Restless legs |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Difficulty sleeping |
| <input type="checkbox"/> Placental Dysfunction | <input type="checkbox"/> Bladder or kidney infection |
| <input type="checkbox"/> Swollen feet and/or hands | <input type="checkbox"/> Pre-eclampsia |
| <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Premature labor |
| <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Threatened Miscarriage |
| <input type="checkbox"/> Pubic Pain | <input type="checkbox"/> Sciatic Pain |
| <input type="checkbox"/> Low back pain | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> Bed rest | <input type="checkbox"/> High risk |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Headache |

What type of birth do you intend on having?

- Vaginal
- Cesarian
- VBAC

Where do you intend on having your baby(s)?

- Home
- Hospital
- Birth Center

Overall pregnancy Experience?

Previous Chiropractor? _____

When was your last visit with them? _____

Have you created a Birth Plan? YES / NO (circle one)

How many children do you have currently (list ages and names)?

Are you currently taking any medications or supplements (please list)? _____

Have you been vaccinated during pregnancy? _____

What is your sleep quality(circle one)? Good/ Fair/ poor How many hours/night? _____

Do you exercise currently(circle one)? Yes / No

What type of exercise and how often? _____

Do you have concerns from a previous pregnancy, labor, birth or postpartum period that you would like to address during this pregnancy? _____

CONSENT TO TREATMENT:

To the best of my knowledge, this form is accurate and complete. I have disclosed all known health conditions and will inform Dr. Chelsea of any changes in my health status at the beginning of future appointments. I agree to discuss my pregnancy as it progresses and I consent to treatment.

Signature: _____ Date: _____