EMPOWER
Family Chiropractic

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:

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