PRENATAL INTAKE

Personal Information:

First name: ________________ **Last name:** __________ **Goes by:** __________________ **Date:** __________
Address: ________________________ **City:** ____________________ **State:**__________ **Zip:** ________
Phone number: ___________________________ **Email:** _______________________________________
Which type of reminders would you like (circle): TEXT | EMAIL
If text reminders, who is your cell phone provider? _________________________
Gender: Male | Female **DOB:** _______________

Marital Status: Single / Married / Widowed Spouses name: ______________________________________
# of children: _______________________ Names/ages: _______________________________________
Emergency contact: _________________ Emergency contact phone number: _____________________
Relation? ______________________
Whom may we thank for referring you? ____

Primary Goal for care:
____
Secondary Goal for care:
____
Week of Pregnancy _________ Due Date ________ Babies Gender: Male / Female / Unknown
Name of Obstetrician/Midwife: ____
Name 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
- ☐ Depression
- ☐ Anxiety
- ☐ Leg Cramps/Restless legs
- ☐ Difficulty sleeping
- ☐ Bladder or kidney infection
- ☐ Pre-eclampsia
- ☐ Thyroid Condition
- ☐ Premature Labor
- ☐ Pubic Pain
- ☐ Low back pain
- ☐ Bed rest
- ☐ Fatigue
- ☐ Heartburn
- ☐ IVF Used
- ☐ Indigestion
- ☐ Constipation
- ☐ Breech/Transverse
- ☐ Threatened Miscarriage
- ☐ Sciatic Pain
- ☐ Neck Pain
- ☐ High risk
- ☐ Headache
- ☐ Other:_______________________

What type of birth do you intend on having?

- ☐ Vaginal
- ☐ Caesarean
- ☐ 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)

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? ____

____

Hobbies and activities you love/loved doing? ____

Employer Information: ☐ Full time ☐ Part time ☐ Homemaker ☐ Unemployed

Employer name: ____________________________ Occupation: ____________________

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 the Doctors 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: ___________________________