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PRENATAL PATIENT INTAKE

Full Name: _____ Date: _____ DOB: _____

Address: _____

Phone number: _____ Email: _____

Marital Status: __ Single __Married __ Widowed Name of Spouse/Partner: _____

Emergency contact, relation and phone #: _____

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
__ 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
__ Excessive stress
__ Other _____

What type of birth do you intend on having? __ Vaginal __ Cesarean __ VBAC

Where do you intend on having your baby(s)? __ Home __ Hospital __ Birth Center

Overall pregnancy Experience?_____

Previous Chiropractor, date of last visit? _____

Have you created a Birth Plan? __ YES __ NO

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? __ Good __ Fair __ Poor How many hours/night? _____

Do you exercise currently? __ Yes __No

What type of exercise and how often? _____

_____

Are you experiencing a high level of stress and/or an un-supported pregnancy? _____

_____

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. Ko 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: _____