Pregnancy Intake Form

Name_______________________________ Date____________________

What is the main concern for which you are seeking treatment? Please give history of condition____

When is your due date? ______________________ How many weeks along are you?_________

Prenatal History

Name of Midwife/Obstetrician__________________ Ultrasounds during pregnancy? Y/N
Please list any medications, herbs or supplements you are taking__________________
Have you smoked or consumed alcohol during pregnancy? Y/N
Is your baby in an in-uterine constraining position such as:
_Breech _Transverse (side lying) _Face/Brow Presentation

Do you have a birth plan? Y/N If so, describe_____________________________________
Do you have a planned C-section? Y/N If so, why?_________________________________
Are you planning a VBAC? Y/N
Have there been any complications during this pregnancy? Y/N Explain__________________
Do you have gestational diabetes? Y/N Do you have high blood pressure? Y/N

Past History

Is this your first pregnancy? Y/N
If you have ever been pregnant:
How many times have you been pregnant? _______
How many full-term babies?_____________ Ages of children?______________________
Please provide details of your previous deliveries (complications, medical interventions, etc)____
____

Were there any complications with any of your other pregnancies? Y/N Explain____________
____
Were your deliveries vaginal? Y/N
Have you ever had a Caesarian-section? Y/N If so, why?____________________________
During previous labours, were medications used? Y/N List____________________________
Were you induced? Y/N

Lifestyle

How is your appetite?
How is your sleep?
If you exercise, what type(s) of exercise do you do and how often?
____

Please check any of the following conditions that you are currently experiencing:

_Anxiety
_Back/Neck/Shoulder Pain
_Blurred Vision
_Carpal Tunnel Syndrome
_Constipation/Diarrhea
_Dizziness
_Other:_________________

_Edema (swelling)
_Fever
_Frequent burning during urination
_Gestational Diabetes
_Headaches

_Sacral or Tailbone Pain
_Nausea
_Ongoing abdominal Pain
_Skin Conditions/Infections
_Vomiting
_Numbness/Tingling

Do you have a history of:

_Autoimmune disease
_Blood Clots
_Chronic Pain
_Heart Disease
_High Blood Pressure
_Infertility Challenges
_Joint Problems

_Kidney Disease
_Miscarriage(s)
_Postpartum Depression &/or Anxiety
_Recent Surgery
_Vertebral disc Problems
_Other:______________________

Please be assured that your information is confidential and will be shared only with your practitioners.