# Client Intake

| **Client** | | | | |
|---|---|---|---|---|
| Name (First Middle Last) | | Maiden Name | Phone # | Email |
| Race | Religion | Occupation | | Yrs Education |
| Date of Birth | State of Birth | SSN # | Marital Status | |
| Street Address | | City, State | Zip Code | |
| **Partner** | | | | |
| Name (First Middle Last) | | | Phone # | Email |
| Race | Religion | Occupation | | Yrs Education |
| Date of Birth | State of Birth | SSN # | | |
| **Father of Baby** **(if different than partner)** | | | | |
| Name (First Middle Last) | | Occupation | Phone # | Email |
| **Emergency Contact** | | | | |
| Name (First Middle Last) | | Relationship | | Phone # |

| | | | |
|---|---|---|---|
| **Planned Place of Birth:** | ○ Home | ○ Birth Center | ○ Undecided |
| **If home, please indicate if you have:** | ○ Water | ○ Electricity | ○ Telephone/Cell Service/Wifi |

| **Family History**<br>*Indicate if anyone in your immediate family has ever had any of these, who; when.* | **Father of Baby (FOB)**<br>*Indicate if the baby's father has ever had any of these; when.* | **Your Mother's History**<br>*Please answer the following regarding your mother.* |
|---|---|---|
| ○ High Blood Pressure:<br>○ Cancer:<br>○ Diabetes:<br>○ Twins:<br>○ Mental Illness:<br>○ Alcohol/Drug Abuse:<br>○ Other: | ○ STI/STDs:<br>○ Genital Herpes:<br>○ Mental Illness:<br>○ Alcohol/Drug Abuse:<br>○ Tobacco Use:<br>○ Other: | # of Pregnancies:<br># of Births:<br>Miscarriages:<br>Pregnancy Complications:<br><br>Your weight at birth: |

Y N Have you or the FOB ever had a baby with a birth condition or developmental delay?

Y N Do you or the FOB have any family members with birth conditions diagnosed as genetic or inherited?

Y N Are you or the FOB from any of these ethnic/racial groups? (circle)
Jewish Black/African Asian Mediterranean

Y N Have you or the FOB ever had hepatitis or jaundice?

Y N Have you ever experienced dramatic fluctuations in your weight?

Y N Have you ever had anorexia, bulimia or other eating problems?

Y N Is there anything about the development of your sexuality that you'd like to discuss?

Y N Have you ever been in an abusive relationship, including now, or been abused (physically or emotionally intimidated, beaten, injured or made to take part in sexual activities against your will)?

Y N Have you ever had mental illness?

Y N Have you ever been on any medication for psychological illness?

Y N Has anyone ever told you, or do you think, you have ever used alcohol or drugs excessively?

**Medical History**
*Indicate if you have ever had any of these; when.*

- ○ Severe Headaches:
- ○ Eye/vision Problems:
- ○ Ear/hearing Problems:
- ○ Dental Problems:
- ○ Thyroid Problems:
- ○ Rheumatic fever:
- ○ Blood Clotting Problems:
- ○ Anemia:
- ○ Hemorrhage:
- ○ High Blood Pressure:
- ○ Varicose Veins:
- ○ Hemorrhoids:
- ○ Tuberculosis:
- ○ Asthma:
- ○ Skin Disorders:
- ○ Stomach Problems:
- ○ Ulcers:
- ○ Chicken Pox:
- ○ Bowel Problems/Colitis:
- ○ Blood in Stool:
- ○ Gall Bladder Problems:
- ○ Liver Problems:
- ○ Hepatitis:
- ○ Diabetes:
- ○ Hypoglycemia:
- ○ Bladder Infection:
- ○ Kidney Infection:
- ○ Urinary Surgery:
- ○ Urethral Dilation:
- ○ Aching Joints:
- ○ Pelvic/Back Injuries:
- ○ Seizures:
- ○ Cancer:
- ○ Hospitalizations:
- ○ Surgeries:
- ○ Other:

**Gynecologic History**
*Indicate if you have ever had any of these; when.*

- ○ Yeast:
- ○ Trichomonas:
- ○ Group B Strep:
- ○ Bacterial Vaginosis:
- ○ Chlamydia:
- ○ Gonorrhea:
- ○ Syphilis:
- ○ PID/Pelvic Infection:
- ○ Genital Sores:
- ○ Genital Herpes:
- ○ Condyloma (Warts):
- ○ Cervicitis:
- ○ Cervical Surgery:
- ○ Cervical Polyp:
- ○ Ovarian Cyst:
- ○ Fibroids:
- ○ Endometriosis:
- ○ Abnormal Bleeding:
- ○ Uterine Surgery:
- ○ Breast Lump(s):
- ○ Breast Surgery:
- ○ Infertility:
- ○ Other:

Age at first menstrual period:

Length of period: days

Duration between periods: days

Pain with periods? Y N

Last Pap smear date:

Have you ever had an abnormal pap; when and how was the follow-up?

Most recent birth control method:

Past contraception; what, when, any issues?

**Height:**

**Pre-Pregnancy Weight:**

**Allergies**
*Indicate if you have any of these; severity and reaction.*

Drug:

Food:

Environmental:

**Lifestyle**

Do you exercise regularly? Y N

How and how often:

Dietary Restrictions:

Relevant cultural/religious preferences:

**Anything else you'd like us to know:**

**Previous Pregnancy Outcomes**

*Please complete this table in regards to your own pregnancies from earliest to most recent.*

| Date Ended or Birth | # Weeks | Birth/Miscarriage/Termination | Hospital/Home/Birth Center | Comments/Issues |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Present Pregnancy**

Last period (1st day):

Was it regular? Y N

Suspected conception date:

Pregnancy test date:

Planned Pregnancy? Y N

Feelings about the pregnancy:

Partners feelings:

*Indicate if you've had any of these during this pregnancy.*

- ○ Nausea
- ○ Vomiting
- ○ Fever
- ○ Infections
- ○ Headache
- ○ Dizziness
- ○ Indigestion
- ○ Leg Cramps
- ○ Rash
- ○ Backache
- ○ Swelling
- ○ Constipation
- ○ Diarrhea
- ○ Urinary complaints
- ○ Abdominal/pelvic pain
- ○ Vaginal bleeding/spotting
- ○ Vaginal discharge
- ○ Bleeding gums
- ○ Varicose veins
- ○ Hemorrhoids
- ○ Depression
- ○ Loneliness
- ○ Family/relationship issues
- ○ Work problems
- ○ Other:

*Indicate use since the knowledge of this pregnancy.*

- ○ Tobacco
- ○ Alcohol
- ○ Caffeine
- ○ Marijuana
- ○ Cocaine
- ○ Other Recreational Drugs:
- ○ Other Medications:
- ○ Herbs:
- ○ Vitamins:

*Indicate exposure during this pregnancy.*

- ○ Fumes/Sprays
- ○ X-rays
- ○ Ultrasound
- ○ Measles/Viruses
- ○ Vaccinations:
- ○ Travel:
- ○ Cats:
- ○ Other: