



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 #		
Partner				
Name (First Middle Last)		Occupation	Phone #	Email
Emergency Contact				
Name (First Middle Last)		Relationship	Phone #	

<p>Family History <i>Indicate if anyone in your immediate family has ever had any of these, who; when.</i></p> <p><input type="checkbox"/> High Blood Pressure: <input type="checkbox"/> Cancer: <input type="checkbox"/> Diabetes: <input type="checkbox"/> Twins: <input type="checkbox"/> Mental Illness: <input type="checkbox"/> Alcohol/Drug Abuse: <input type="checkbox"/> Other:</p>	<p>Partner History <i>Indicate if the baby's father has ever had any of these; when.</i></p> <p><input type="checkbox"/> STI/STDs: <input type="checkbox"/> Genital Herpes: <input type="checkbox"/> Mental Illness: <input type="checkbox"/> Alcohol/Drug Abuse: <input type="checkbox"/> Tobacco Use: <input type="checkbox"/> Other:</p>	<p>Your Mother's History <i>Please answer the following regarding your mother.</i></p> <p># of Pregnancies: # of Births: Miscarriages: Pregnancy Complications:</p> <p>Your weight at birth:</p>
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- Y N Have you or your partner ever had a baby with a birth condition or developmental delay?
- Y N Do you or your partner have family members with birth conditions diagnosed as genetic or inherited?
- Y N Are you or your partner from any of these groups? (circle)
Jewish Black/African Asian Mediterranean
- Y N Have you or your partner 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 <i>Indicate if you have ever had any of these; when.</i> <ul style="list-style-type: none"> <input type="checkbox"/> Severe Headaches: <input type="checkbox"/> Eye/Vision Problems: <input type="checkbox"/> Ear/hearing Problems: <input type="checkbox"/> Dental Problems: <input type="checkbox"/> Thyroid Problems: <input type="checkbox"/> Rheumatic fever: <input type="checkbox"/> Blood Clotting Problems: <input type="checkbox"/> Anemia: <input type="checkbox"/> Hemorrhage: <input type="checkbox"/> High Blood Pressure: <input type="checkbox"/> Varicose Veins: <input type="checkbox"/> Hemorrhoids: <input type="checkbox"/> Tuberculosis: <input type="checkbox"/> Asthma: <input type="checkbox"/> Skin Disorders: <input type="checkbox"/> Stomach Problems: <input type="checkbox"/> Ulcers: <input type="checkbox"/> Chicken Pox: <input type="checkbox"/> Bowel Problems/Colitis: <input type="checkbox"/> Blood in Stool: <input type="checkbox"/> Gall Bladder Problems: <input type="checkbox"/> Liver Problems: <input type="checkbox"/> Hepatitis: <input type="checkbox"/> Diabetes: <input type="checkbox"/> Hypoglycemia: <input type="checkbox"/> Bladder Infection: <input type="checkbox"/> Kidney Infection: <input type="checkbox"/> Urinary Surgery: <input type="checkbox"/> Urethral Dilation: <input type="checkbox"/> Aching Joints: <input type="checkbox"/> Pelvic/Back Injuries: <input type="checkbox"/> Seizures: <input type="checkbox"/> Cancer: <input type="checkbox"/> Hospitalizations: <input type="checkbox"/> Surgeries: <input type="checkbox"/> Other: 		Gynecologic History <i>Indicate if you have ever had any of these; when.</i> <ul style="list-style-type: none"> <input type="checkbox"/> Yeast: <input type="checkbox"/> Trichomonas: <input type="checkbox"/> Group B Strep: <input type="checkbox"/> Bacterial Vaginosis: <input type="checkbox"/> Chlamydia: <input type="checkbox"/> Gonorrhea: <input type="checkbox"/> Syphilis: <input type="checkbox"/> PID/Pelvic Infection: <input type="checkbox"/> Genital Sores: <input type="checkbox"/> Genital Herpes: <input type="checkbox"/> Condyloma (Warts): <input type="checkbox"/> Cervicitis: <input type="checkbox"/> Cervical Surgery: <input type="checkbox"/> Cervical Polyp: <input type="checkbox"/> Ovarian Cyst: <input type="checkbox"/> Fibroids: <input type="checkbox"/> Endometriosis: <input type="checkbox"/> Abnormal Bleeding: <input type="checkbox"/> Uterine Surgery: <input type="checkbox"/> Breast Lump(s): <input type="checkbox"/> Breast Surgery: <input type="checkbox"/> Infertility: <input type="checkbox"/> Other: <p>Age at first menstrual period: _____</p> <p>Length of period: _____ days</p> <p>Duration between periods: _____ days</p> <p>Pain with periods? Y N</p> <p>Last Pap smear date: _____</p> <p>Have you ever had an abnormal pap; when and how was the follow-up? _____</p> <p>Most recent birth control method: _____</p> <p>Past contraception; what, when, any issues? _____</p>	
Height: Weight:	Allergies <i>Indicate if you have any of these; severity and reaction.</i> 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					<i>Please complete this table in regards to your own pregnancies from earliest to most recent.</i>
Date Ended or Birth	# Weeks	Birth/Miscarriage/Termination	Hospital/Home/Birth Center	Comments/Issues	

<i>Indicate if you've have recently experienced any of the following:</i> <ul style="list-style-type: none"> <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Fever <input type="checkbox"/> Infections <input type="checkbox"/> Headache <input type="checkbox"/> Dizziness <input type="checkbox"/> Indigestion <input type="checkbox"/> Leg Cramps <input type="checkbox"/> Rash <input type="checkbox"/> Backache <input type="checkbox"/> Swelling <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Urinary complaints <input type="checkbox"/> Abdominal/pelvic pain <input type="checkbox"/> Vaginal bleeding/spotting <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Bleeding gums <input type="checkbox"/> Varicose veins <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Depression <input type="checkbox"/> Loneliness <input type="checkbox"/> Family/relationship issues <input type="checkbox"/> Work problems <input type="checkbox"/> Other: 	<i>Indicate recent use:</i> <ul style="list-style-type: none"> <input type="checkbox"/> Tobacco <input type="checkbox"/> Alcohol <input type="checkbox"/> Caffeine <input type="checkbox"/> Marijuana <input type="checkbox"/> Cocaine <input type="checkbox"/> Other Recreational Drugs: <input type="checkbox"/> Other Medications: <input type="checkbox"/> Herbs: <input type="checkbox"/> Vitamins: 	<i>Indicate exposure during the last year:</i> <ul style="list-style-type: none"> <input type="checkbox"/> Fumes/Sprays <input type="checkbox"/> X-rays <input type="checkbox"/> Ultrasound <input type="checkbox"/> Measles/Viruses <input type="checkbox"/> Vaccinations: <input type="checkbox"/> Travel: <input type="checkbox"/> Cats: <input type="checkbox"/> Other:
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