Client Intake and Health History

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Full Current Legal Name_____ Maiden Name_____

Street Address_____City, State, Zip_____

Occupation_____ Email Address_____

Home Phone_____ Cell_____ Work_____

SSN_____ Date of Birth_____ State of Birth_____

Father of Baby's Full Legal Name_____

Occupation_____ Home Phone_____ Cell_____

SSN_____ Date of Birth_____ State of Birth_____

Are you legally married? Yes No

Current Pregnancy

Please circle any of the following problems you have experienced during this pregnancy:

Nausea Headache Leg Cramps Swelling Urinary Problems Vaginal Discharge Indigestion

Bleeding Gums Vomiting Dizziness Fever Constipation Hemorrhoids Varicose Veins

Abdominal/Pelvic Pain Vaginal Bleeding/ Spotting Backache Diarrhea Restless Leg Syndrome

Loneliness Family Problems Relationship Problems Depression Work Problems

Notes:_____

When do you think you conceived?_____

Have you had a positive pregnancy test? Yes No If yes, when? _____

Was this a planned pregnancy? Yes No

What are your feelings about this pregnancy?_____

_____

Were you using birth control? Yes No If yes, what kind?_____

Are you taking prenatal vitamins? Yes No If yes, what kind and when did you start?_____

Obstetric History

Total pregnancies including current _____ Miscarriages_____ Abortions_____Premature_____Term_____

Date last pregnancy ended_____ Your weight: Pre-pregnancy_____ Current_____

Height_____ Name of midwife or doctor seen during this pregnancy_____

	Child 1	Child 2	Child 3	Child 4	Child 5
Name					
Date of birth					
Location					
Weeks Gestation					
1st Sign of Labor					
Length of Labor					
Length of Pushing					
IV/ Induction?					
IV Pain Meds?					
Pitocin?					
Epidural?					
Tear/ Episiotomy?					
Vacuum/ Forceps?					
Vaginal Birth?					
Position of Baby					
Meconium?					
Weight of baby					
Complications?					
Hemorrhage/ Transfusion?					
Breastfed? How long?					
Contraception after?					
Depression Postpartum?					

Gynecological History

Please circle any of the following conditions you or your partner have had or currently have:

Yeast Infection Bacterial vaginosis (BV) Syphilis Genital Herpes Cervicitis Ovarian Cyst

Abnormal Bleeding Breast Surgery Trichomoniasis (Trich) Chlamydia PID Cervical Surgery

Oral Herpes (Cold Sores) Fibroids Uterine Surgery Infertility HIV Abnormal Pap HPV

Gonorrhea Genital Sores Condyloma (Warts) Cervical Polyps Endometriosis Breast Lumps

DES Exposure D&C PCOS LEEP Procedure Conization Myomectomy Cryosurgery

Cesarean Surgery

Notes on above:_____

_____

_____

What kind of family planning or birth control have you used in the past?_____

_____

Any problems or complications from them?_____

_____

When was your last Pap smear?_____ Was it normal?_____

Menstrual History

How old were you when your periods began?_____ How many days do they last?_____

My periods are usually? Painful Light Medium Heavy Very heavy

What was the FIRST day of your last period?_____ Are your sure?_____ Was it normal?_____

Health History

Circle any of the following conditions that you or any of your close relatives have had:

High Blood Pressure Heart Condition Tuberculosis Diabetes Epilepsy Thyroid Problems

Severe Emotional Problems Cancer Twins

Notes:_____

_____

Circle any of the following that YOU ONLY have had:

Kidney Disease Surgeries Urinary Tract Surgery Hemorrhage Pelvic/Back Injuries Cravings

Skin Problems Phlebitis/ Varicose Veins Allergies Stomach Problems Severe Headaches

Bowel Problems Dental Problems Blood Clotting Problems Bladder Infection Hemorrhoids

Asthma Anemia Hepatitis Hospitalization Liver Problems Seizures Severe Accidents

Constipation Insomnia Blood Transfusion Gall Bladder Problems Hypoglycemia

Joint/Muscle Problems Other:_____

Notes:_____

Are you: Underweight Overweight Average

What medications have you taken since your last period?_____

Do you have any known allergies to medications?_____

Additional Information

How many times was your mother pregnant?_____ How many children did she have?_____

Did she have any miscarriages, how many?_____ How long were her labors?_____

Were there any complications in any of her pregnancies?_____

How much did you weigh at birth?_____ Your baby's father?_____

Do you have any sisters who have given birth?_____ How long were their labors?_____

Did they have any complications in pregnancy or birth?_____

_____

Do you suffer from anxiety or depression? Yes No

Have you ever suffered from an eating disorder? Yes No If yes, please describe_____

Have you been in an abusive relationship in the past? Yes No Maybe

Are you in an abusive relationship now? Yes No Maybe

Have you ever had non-consensual sex? Yes No Maybe

Were you sexually abused or molested as a child? Yes No Maybe

Are you monogamous? Yes No

Do you have, or have you ever had, a drug problem? Yes No

Have you ever used intravenous (injected) drugs? Yes No

Have you ever had a blood transfusion? Yes No If yes, when and where?_____

Do you think you are at an increased risk for HIV/ AIDS? Yes No

How many alcoholic drinks have you had in the past week? _____ Month?____ Since pregnant?_____

Do you smoke? Yes No If yes, how many per day?_____

If you smoked in the past, but don't now, when did you quit?_____

Do you believe your baby could be at risk for any hereditary medical conditions? Yes No

If yes, which ones:_____

Circle all of the following that you have used or been exposed to during this pregnancy:

Tobacco Caffeine Alcohol Marijuana Cocaine Street Drugs Viruses Measles Cats

X-Ray Vaccinations Ultrasound Herbs Vitamins Non-prescription Drugs Prescription Drugs

Fumes/ Sprays/ Pesticides Other Hazards (including occupational)

How would you describe your usual diet?_____

_____

Why do you want to hire and use a midwife?_____

_____

Why do you desire to plan a home birth?_____

_____

Do you have any ethnic, cultural, or religious preferences for your care?_____

_____

How did you find out about us?_____

Is there anything else that you would like to share?_____

_____

	Friday	Protein Count	Saturday	Protein Count	Sunday	Protein Count	Monday	Protein Count	Tuesday	Protein Count	Wednesday	Protein Count	Thursday	Protein Count
Meal														
Breakfast														
Snack														
Lunch														
Snack														
Dinner														
Snack														
Protein Total														

□□□□ Milk Product
□□ Eggs
□□ Protein
□□ Leafy Green
□ Veggies
□□□□ Grains
□ Vit. C
□□□ Fats
□ Fruits
□ Water to thirst
□ Salt to taste

□□□□Milk Product
□□ Eggs
□□ Protein
□□ Leafy Green
□ Veggies
□□□□ Grains
□ Vit. C
□□□ Fats
□ Fruits
□ Water to thirst
□ Salt to taste

□□□□Milk Product
□□ Eggs
□□ Protein
□□ Leafy Green
□ Veggies
□□□□ Grains
□ Vit. C
□□□ Fats
□ Fruits
□ Water to thirst
□ Salt to taste

□□□□ Milk Product
□□ Eggs
□□ Protein
□□ Leafy Green
□ Veggies
□□□□ Grains
□ Vit. C
□□□ Fats
□ Fruits
□ Water to thirst
□ Salt to taste

□□□□Milk Product
□□ Eggs
□□ Protein
□□ Leafy Green
□ Veggies
□□□□ Grains
□ Vit. C
□□□ Fats
□ Fruits
□ Water to thirst
□ Salt to taste

□□□□Milk Product
□□ Eggs
□□ Protein
□□ Leafy Green
□ Veggies
□□□□ Grains
□ Vit. C
□□□ Fats
□ Fruits
□ Water to thirst
□ Salt to taste

□□□□ Yellow or orange fruits and vegetables (5X/week)

Please complete this nutrition worksheet so that I can have an idea of what kinds of food you are eating! Try to record the amount of protein you think you are getting with each meal.