

Client Information Form

Please complete this form in preparation for your initial visit. The information is required for completion of your chart and will be kept confidential.

Name: First Middle Last (Maiden)			Employer:	
Address:			Emp. Address:	State: Zip:
City:	State:	Zip:	Emp. Phone:	Position:
Phone #:	E-mail address:		How long at present Employer?	Do you have insurance? Yes No
Marital Status: M S C (Please circle)			Insurance Co.:	
Birth Date:	Birthplace: (State or foreign country)		Ins. Address:	
Education (highest grade completed):			Ins. Phone:	State:
Social Security Number:			Policy or Group #:	
Drivers License*			Subscriber ID #:	
Medicaid* (if applicable):				
Father's Name:				
Birth Date:	Birthplace: (state or foreign country)		How long at present Employer?	
Education: (highest grade completed)			Do you have Insurance? Yes No	
Driver's License #:			Insurance Co.:	
Social Security Number:			Ins. Address:	
Employer:			Ins. Phone:	
Employer Address:			Policy or Group #:	
Phone:	Position:		Subscriber ID #:	
Person financially responsible for this account:				
Physician's Name:			Address:	
			Phone:	
Any religious preference you would like me to know about?				
Nearest relative not residing with you:			Phone:	
Whom may we thank for referring you?			Phone:	
In case of emergency please contact:			Phone:	

Client Registration (please print)

Please complete this form in preparation for your Initial visit. Your responses will be kept completely confidential. In the event your records are copied for another care provider, this page will not be copied. If you need more space, please use the area provided at the end.

YOUR FAMILY HISTORY

Indicate if anyone in your immediate family has ever had any of these; who; when.

- High blood pressure,
- Cancer _____
- Diabetes _____
- Twins _____
- Severe emotional problems _____
- Alcohol/drug abuse _____
- Other _____

FATHER OF BABY

Indicate if the baby's father has ever had any of these; when.

- Sexually transmitted diseases
- Severe emotional problems
- Alcohol/drug abuse _____
- Tobacco use
- Family history of twins
- Other _____

YOUR MOTHER'S HISTORY

Please answer the following regarding your mother.

- No. of pregnancies _____
- No. of live births _____
- Miscarriages _____
- Any complications _____
- Your weight at birth _____
- Did she take DES while pregnant with you? Yes No

GYNECOLOGICAL HISTORY

Age at 1st period? _____

Average Cycle length (days) _____ Duration _____ Regular?

When was your last Pap smear? _____

Have you ever had an abnormal Pap? Yes No If so, when?

Contraception used in past: what, when, any problems?

PRESENT PREGNANCY

Last menstrual period (1st day) _____ Normal? Yes No (If not normal, 1st day of last normal menstrual period _____)

Suspected date of conception _____

Pregnancy test (date) _____

Planned pregnancy? Yes No

How are you feeling about this pregnancy? _____

Do you have any allergies to any medications? Yes No

Are there any particular ethnic, cultural, or religious preferences for your care during pregnancy and birth that you'd like to discuss? _____

During this pregnancy have you had or do you have any of the following:

<input type="checkbox"/> Nausea	<input type="checkbox"/> Rash	<input type="checkbox"/> Varicose veins
<input type="checkbox"/> Vomiting	<input type="checkbox"/> Backache	<input type="checkbox"/> Hemorrhoids
<input type="checkbox"/> Fever	<input type="checkbox"/> Swelling	<input type="checkbox"/> Loneliness
<input type="checkbox"/> Headache	<input type="checkbox"/> Constipation	<input type="checkbox"/> Depression
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Diarrhea	Other:
<input type="checkbox"/> Indigestion	<input type="checkbox"/> Vaginal discharge	
<input type="checkbox"/> Leg Cramps	<input type="checkbox"/> Bleeding	

Previous Pregnancies (please include miscarriages as SAB or abortions as TOP with approximate dates and weeks). Additional pregnancies, if necessary, can be added on an additional page.

	1	2	3	4	5	6
Date						
Where delivered						
Sex						
Name						
Weeks gestation						
Hours/ labor: Early						
Active						
Pushing						
Placenta						
Type of delivery: vag/extract/c/sec						
Induced, what means						
Presentation: Vertex/Breech						
Hemorrhage (did you need pitocin?)						
Baby's weight at birth						
Apgar						
Breastfed? How long?						
Present health of child?						
Comments/Complications						

Please answer the following questions which will help determine if there are potential problems which should be discussed further. Again, this information is completely confidential.

Have you or the father of the baby (FOB) ever had a baby with a birth defect or mental retardation?	Yes	No
Do you or the FOB have any family members with birth defects or conditions diagnosed as genetic or inherited?	Yes	No
Are you or the FOB related by blood? (e.g. cousins)	Yes	No
Are you or the FOB from any of these ethnic/racial groups? (circle)	Circle One:	Jewish Black/African Asian Mediterranean Eskimo Haitian
Have you or the FOB ever had hepatitis or jaundice?	Yes	No
Have you ever used any drug intravenously (IV) or had a blood transfusion?	Yes	No
Have you ever had a sexual partner who used any drug IV, had a blood transfusion, or had bisexual relations?	Yes	No
Have you had more than five sexual partners in the past five years?	Yes	No
Do you think you are at increased risk for having a baby with a birth defect or genetic problem?	Yes	No
Do you think you are at increased risk for hepatitis?	Yes	No
Do you think you are at increased risk for AIDS/HIV?	Yes	No
Have you ever experienced dramatic fluctuations in your weight?	Yes	No
Have you ever had anorexia, bulimia or eating problems?	Yes	No
Is there anything about the development of your sexuality that you would like to discuss?	Yes	No
Do you feel a need to discuss with me privately any history of an abusive relationship (including physical abuse or emotional intimidation or having been beaten, injured or made to take part in sexual activities against your will)?	Yes	No

Have you ever had severe emotional problems?	Yes	No
Has anyone ever told you, or do you think, you have ever used alcohol or drugs excessively?	Yes	No

MEDICAL HISTORY

Please indicate if you have ever had any of these; when:

<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"/> Allergies
<input type="checkbox"/> Stomach problems
<input type="checkbox"/> Ulcer
<input type="checkbox"/> Abdominal/Pelvic Pain
<input type="checkbox"/> Urinary complaints

<input type="checkbox"/> Bowel problems
<input type="checkbox"/> 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"/> Hospitalizations
<input type="checkbox"/> Surgeries
<input type="checkbox"/> Other
<input type="checkbox"/> Family relationship problems/Work problems

Please indicate if you have ever had any of these; when:

<input type="checkbox"/> Yeast	<input type="checkbox"/> Cervicitis
<input type="checkbox"/> Trichomonas	<input type="checkbox"/> Cervical surgery
<input type="checkbox"/> Gardnerella	<input type="checkbox"/> Cervical polyp
<input type="checkbox"/> Bacterial vaginosis	<input type="checkbox"/> Ovarian cyst
<input type="checkbox"/> Chlamydia	<input type="checkbox"/> Fibroids
<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Abnormal bleeding
<input type="checkbox"/> Syphilis	<input type="checkbox"/> Uterine surgery
<input type="checkbox"/> PID	<input type="checkbox"/> Breast lump(s)
<input type="checkbox"/> Genital sores	<input type="checkbox"/> Breast surgery
<input type="checkbox"/> Herpes: genital; oral	<input type="checkbox"/> Infertility
<input type="checkbox"/> Condyloma (warts)	<input type="checkbox"/> Other
<input type="checkbox"/> Endometriosis	

Please indicate if you are currently taking, have used or been exposed to any of the following during this pregnancy:

<input type="checkbox"/> Tobacco	<input type="checkbox"/> Fumes/sprays
<input type="checkbox"/> Alcohol	<input type="checkbox"/> X-Rays
<input type="checkbox"/> Caffeine	<input type="checkbox"/> Ultrasound
<input type="checkbox"/> Prescription drugs	<input type="checkbox"/> Measles
<input type="checkbox"/> OTC Medications	<input type="checkbox"/> Fifth Disease
<input type="checkbox"/> Marijuana	<input type="checkbox"/> Viruses
<input type="checkbox"/> Cocaine	<input type="checkbox"/> Vaccinations
<input type="checkbox"/> Methamphetamine	<input type="checkbox"/> Cats
<input type="checkbox"/> Street drugs	
<input type="checkbox"/> Other:	

Are you currently taking? If so, how much?

- Prenatal Vitamins:
- Other Vitamins:
- DHA:
- Herbs:
- Other:

If there is ever a time you have concerns about your personal safety or would like certain issues regarding your pregnancy or personal life not discussed in front of your family/friends during prenatal visits, please let us know!