# Prenatal Intake Form

**Name:** ____________________________________ **Today's Date:** ________________

**Nickname:** _____________ **DOB:**______________ **Phone:** _______________________

**Email:** ___________________________ **Marital Status:**_____ **Spouse's Name**______________

**Address:**______________________________ **City:**_______________ **State:**_____ **Zip:**______

**Occupation:** ____________________ **Employer:**_________________________

**Referred by:** _______________________________

**Emergency Contact:**_______________________ **Contact:**__________________

**Relation:**_______________

Week of Pregnancy:___________ Due Date:____________

Name of Obstetrician/Midwife:_______________________________________

Name of Practice:___________________________________________________

Name of Doula:______________________ Are you interested in a doula referral?__________

Are you participating in a pre-natal exercise program?______ Where?____________________

Are you attending birthing classes or coaching?_____ Where?___________________________

Prior to pregnancy was your menstrual cycle: Regular Irregular

Did you experience any: Cramps PMS symptoms Other

Were you on birth control pills?_____ How long did you take them?________

Have you created a birth plan? YES NO

Where do you intend on having your baby: Home Hospital Birth center

Name of hospital/center:__________________________

What type of birth do you intend on having? Vaginal Cesarean VBAC

Overall pregnancy experience?______________________________________________________

Serous medical conditions and/or surgeries:_____________________________________________

Have you been to a chiropractor before? YES NO

Are you taking any medications or supplements?___________________________________

_______________________________________________________________________________

**Previous Pregnancies- Place an X next to all that apply**

| **Year** | Vaginal | Extraction | C-Section | Vacuum | Epidural | Pitocin | Induced labor |
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Did you require an episiotomy for any of the deliveries? YES NO

Have you ever had a miscarriage? YES NO

Were any of your previous babies in a breech position at the time of delivery? YES NO

**Please check if any of these pertain to you:**

- ☐ Over the age of 36
- ☐ First pregnancy
- ☐ Pregnant with multiples
- ☐ Morning sickness, vomiting, nausea
- ☐ Gestational diabetes
- ☐ High blood pressure
- ☐ Placental dysfunction
- ☐ Swollen feet and/or hands
- ☐ Varicose veins
- ☐ Pubic pain
- ☐ Premature labor
- ☐ Sciatic pain
- ☐ Neck pain
- ☐ Low back pain
- ☐ Bed rest
- ☐ IVF used
- ☐ Heartburn
- ☐ Indigestion
- ☐ Constipation
- ☐ Breech or transverse baby
- ☐ Leg cramps/restless legs
- ☐ Difficulty sleeping
- ☐ Bladder or kidney infection
- ☐ Pre-eclampsia
- ☐ High risk

Is there anything else you would like to communicate about your pregnancy to optimize your care?

____________________________________________________________

____________________________________________________________

Are you interested in learning about therapeutic massage? YES NO

Are you interested in learning about nutritional supplementation counseling? YES NO

Consent to treatment: To the best of my knowledge, this form is accurate and complete. I have disclosed all known health conditions and will inform Dr. Lundy of any changes in my health status at the beginning of future appointments. I consent to treatment.

Signature____________________________________ Date:____________________

## Informed Consent to Join Manipulation/Mobilization and Care

**Dr. April Lundy**

**1241 Canton St. Suite 100 Roswell, GA 30075**

**404-400-3332**

I hereby request and consent to the performance of joint manipulations/mobilizations and other procedures including various modes of physiotherapy and diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible) by the doctor/s named above and/or other licensed doctor/s who now or in the future treat me while employed by working or associated with serving as back up for the doctor/s or with the doctor/s named above, including those working at the clinic or office listed above.

I have had an opportunity to discuss with the doctor/s named above and/or with other office or clinic personnel the nature and purpose of joint manipulations/mobilization and other procedures. I understand that results are not guaranteed.

I understand and am informed that as in the practice of medicine, chiropractic and physiotherapy there are some risks to the treatments including but not limited to reactions to modalities, fractures and strains. I do not expect the doctor/s to be able to anticipate and explain all risks and/or complications, and I wish to rely on the doctor/s to exercise judgement during the course of the procedures which the doctor/s feels at the time, based on fact then known, is in my best interests.

I have read, or have read to me above consent. I have also had an opportunity to ask questions about its content and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

TO BE COMPLETED BY PATIENT OR PATIENT'S REPRESENTATIVE, IF NECESSARY, e.g., IF PATIENT IS A MINOR OR PHYSICALLY OR LEGALLY INCAPACITATED:

| ______________________ | ______________________ | __________ |
|---|---|---|
| Print Patient's Name | Signature | Date |
| ______________________ | ______________________ | __________ |
| Representative | Relationship | Date |

Witness:____________________________________________