NEW PATIENT INTAKE FORM – POSTNATAL

PERSONAL INFORMATION

Full Name: AHC#:

Phone Number: Date of Birth: / /

Home Address:

City: Province: Postal Code:

Gender: ☐ Male ☐ Female ☐ Non-Binary ☐ Prefer Not to Say

Emergency Contact Name: Relationship: Phone:

BIRTH HISTORY

Baby's Age: _____ Is this your first pregnancy: ☐ Yes ☐ No

Type of delivery: ☐ Vaginal ☐ Assisted ☐ C-Section

Any complications? _____

REASON FOR SEEKING CARE

What brings you into our office?

_____

_____

How long has this been present? ☐ Recent ☐ Weeks ☐ Months ☐ Years

Have you experienced this before? ☐ Yes ☐ No

POSTNATAL GOALS

What are your goals for your health, and care?

☐ Healing and recovery ☐ Core/pelvic stability ☐ Energy and sleep

☐ Nervous system support ☐ Return to activity

Other: _____

CURRENT HEALTH

Please describe any current pain or discomfort, including the location and any relevant details.

_____

_____

_____

_____

LIFESTYLE

Activity Level: ☐ Sedentary ☐ Moderate ☐ Active ☐ Athlete

Current movement/exercise:

_____

_____

SLEEP & ENERGY

Hours of sleep per night: _____

Sleep quality: ☐ Restful ☐ Interrupted ☐ Poor

Energy: ☐ High ☐ Moderate ☐ Low

STRESS LEVELS

Stress during pregnancy: ☐ Low ☐ Moderate ☐ High

Stress postnatal: ☐ Low ☐ Moderate ☐ High

NUTRITION

Meals per day: _____

Carbohydrates: ☐ Low ☐ Moderate ☐ High

Protein: ☐ Low ☐ Moderate ☐ High

Fats: ☐ Low ☐ Moderate ☐ High

Sugars: ☐ Low ☐ Moderate ☐ High

Water Intake: ☐ Low ☐ Moderate ☐ High

Gluten intake: ☐ Low ☐ Moderate ☐ High

Dairy intake: ☐ Low ☐ Moderate ☐ High

Water Intake: ☐ Low ☐ Moderate ☐ High

High processed foods: ☐ Low ☐ Moderate ☐ High

FINAL NOTES

Is there anything else you would like us to know about your health, or care intentions?

_____

_____

_____

_____

_____