NEW PATIENT INTAKE FORM – PRENATAL

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:

PREGNANCY INFORMATION

Weeks pregnant: _____ Due date: _____

Birth support team: ☐ Midwife ☐ Doula ☐ OB ☐ Family Physician

Names: _____

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

PREGNANCY GOALS

What are your goals for your health, and care?

☐ Comfort during pregnancy ☐ Nervous system regulation ☐ Support baby positioning

☐ Optimal pelvic alignment ☐ Prepare for birth

Other: _____

CONCEPTION & PREGNANCY HISTORY

Was conception: ☐ Natural ☐ Assisted

If natural, how long to conceive? _____

Morning sickness: ☐ None ☐ Mild ☐ Moderate ☐ Severe

Medications during pregnancy: _____

LIFESTYLE DURING PREGNANCY

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 prior to pregnancy: ☐ Low ☐ Moderate ☐ High

NUTRITION DURING PREGNANCY

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

BIRTH GOALS & PREFERENCES

Is there anything else you would like us to know about your pregnancy/birth goals, or care intentions?

_____

_____

_____

_____

_____