Patient Intake Form

Pregnancy • Labour • Postpartum Wellness

Name: _____

Birthdate: (month/day/year) _____

Address: _____

Phone: home _____
cell _____
work _____

Email: _____

Occupation: _____

Doctor: _____
phone: _____

Midwife/Doula: _____
phone: _____

Emergency Contact: _____
phone: _____

How did you hear about Acumamas Wellness? _____

Please indicate if the following apply to you:

(please mark P = past C = current)

- ☐ Heart Attack
- ☐ High/Low Blood Pressure
- ☐ Stroke or Aneurysm
- ☐ Pace Maker
- ☐ Other Heart Condition _____
- ☐ Varicose Veins
- ☐ Bruise easily
- ☐ Other Circulatory Condition _____
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Other Urinary Condition _____
- ☐ Headaches/Migraines
- ☐ Dizziness/ Fainting
- ☐ Nausea
- ☐ Spinal Injury
- ☐ Head Injury
- ☐ Epilepsy/other seizures
- ☐ Other Neurological Condition _____
- ☐ Asthma
- ☐ Chronic Sinusitis
- ☐ Other Respiratory Condition _____
- ☐ Irritable Bowel/ Colitis
- ☐ Digestive Condition
- ☐ Skin Condition
- ☐ Joint Dislocation
- ☐ Bone Fracture
- ☐ Arthritis
- ☐ Osteoporosis/ Osteopenia
- ☐ Rods/ Pins/ Plates/ Shunts
- ☐ Implants
- ☐ Transplant
- ☐ Cancer
- ☐ Hepatitis
- ☐ HIV/ AIDS
- ☐ Other Contagious Condition _____

Pregnancy

Due date: _____

Miscarriages (date): _____

# of children: _____

What fertility treatments were used (if any): _____

List any complications experienced in this or past pregnancies:

Please briefly describe your Birth Plan:

Medications/Allergies

Medications/ Supplements: _____

Allergies: _____