Prenatal Intake

Full name: ______________________Goes by: _________________________ Date ___/___/___
Address: ________________________ City: _________________________
State:___________ Zip: ________
Phone #: __________________ Email: ______________________________________
Which type of reminders would you like (circle): TEXT | EMAIL
If text reminders, who is your cell phone provider? ________________________
DOB: _______________ Age: ____________
Marital Status: ______ Partner name: ________________________ # of children: _______
Emergency contact: ________________ Phone number: ___________ Relation? ____________
Whom may we thank for referring you? ____

Estimated due date:____/_____/_____
How many weeks pregnant are you currently: ______
Where do you plan on delivering:____
Do you intend on having a birth that is: Vaginal / Caesarean / VBAC
Name of Obstretrician / Midwife:____
Name of Practice: ___________________ May we contact them: Y / N
Name of Doula:______________________
Name of Practice:___________________ May we contact them: Y / N

Please circle if any of the following pertain to you:

First pregnancy	Placental dysfunction	Heart burn
Pregnant with multiples	Breech / Transverse	Restless Leg Syndrome
Over the age of 36	Swollen hands / feet	Difficulty sleeping
IVF or IUI used	Varicose veins	Pre-eclampsia
Morning sickness	Pubic pain	Premature labor
Gestational diabetes	Bed rest	Threatened miscarriage
Placental dysfunction	Sciatic Pain	High risk

Please describe any other symptoms you are experiencing:
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Are you working currently (circle one) YES / NO
Occupation: ______________________________ Employer: ____
Job duties: ____
____
Previous surgeries____
Previous auto accidents / injuries: ____
Medications currently taking: ____
Vitamins/supplements currently taking: ____ _
____
How many hours of sleep do you get per night? _______
Quality of sleep (circle): POOR | MODERATE | GREAT
Hobbies: ____
Current Exercise Regimen: ____
DO you have any concerns regarding a previous pregnancy, labor, or postpartum period?
____

Consent to Chiropractic care:

I hereby request and consent to chiropractic adjustments and other procedures by Doctors Kramer and their staff who now or in the future treat me while employed by this office. I will have an opportunity to discuss with TOLC personnel the nature and purpose of treatment indicated. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to anticipate and explain all risks and complications, and wish to rely on the Doctors to exercise judgement during the course of any procedure which the Doctors feel at that time is in my best interest. I understand that TOLC will not be held responsible for any preexisting medical conditions. I certify that the information contained in my health history is correct to the best of my knowledge. I will not hold my doctor or any staff member of TOLC responsible for any errors or omissions that I may have made in completion of this form. I have read, or have had read to me, the full above consent and have also had an opportunity to ask questions about its consent and by signing below I agree to the above terms and procedures. I intend this consent to cover any treatment for my present condition and for any future care provided by this clinic and/or employed staff.

Patient signature: ____ Date: __________________