



PRENATAL INTAKE

Patient Information:

Name: _____ Date: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Phone: _____ (c) _____ (h)

Date of Birth: _____ (YYYY/MM/DD) Age: _____ Sex: M / F / _____

Occupation: _____ Email: _____

By providing my email I agree to receiving clinic email reminders, health updates, promotions, etc.

In case of emergency, who should we contact?: _____

How did you find out about our services? _____

Prenatal Information:

Gestational Weeks: _____ Due Date: _____

This is my _____ (1st, 2nd, etc.) pregnancy This will be my _____ (1st, 2nd, etc.) birth

I am: **low risk pregnancy** **high-risk pregnancy**, according to my health care provider

My prenatal care provider is: _____ Ph: _____

May we contact your care provider? Yes No

Please **check** current health concerns/problems, **star** any that you have had in the past:

- | | |
|---|---|
| <input type="checkbox"/> abdominal cramping | <input type="checkbox"/> leaking amniotic fluid |
| <input type="checkbox"/> anemia | <input type="checkbox"/> leg cramps |
| <input type="checkbox"/> bladder infection | <input type="checkbox"/> low blood pressure |
| <input type="checkbox"/> blood clot/phlebitis | <input type="checkbox"/> miscarriage, how many? _____ |
| <input type="checkbox"/> breech presentation | <input type="checkbox"/> muscle sprain/strain |
| <input type="checkbox"/> carpal tunnel syndrome | <input type="checkbox"/> nausea/vomiting |
| <input type="checkbox"/> chronic hypertension | <input type="checkbox"/> pre-eclampsia |

- | | |
|---|--|
| <input type="checkbox"/> constipation | <input type="checkbox"/> placenta previa (other abnormalities) |
| <input type="checkbox"/> diabetes (gestational or mellitus) | <input type="checkbox"/> pre-term labour |
| <input type="checkbox"/> dizziness/light-headedness | <input type="checkbox"/> previous caesarean section |
| <input type="checkbox"/> edema/swelling | <input type="checkbox"/> sciatica |
| <input type="checkbox"/> fatigue | <input type="checkbox"/> separation of abdominal muscles |
| <input type="checkbox"/> headaches | <input type="checkbox"/> separation of pubic symphysis |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> twins plus |
| <input type="checkbox"/> heart burn/acid reflux | <input type="checkbox"/> uterine bleeding |
| <input type="checkbox"/> hypo or hyperglycaemia | <input type="checkbox"/> varicose veins |
| <input type="checkbox"/> insomnia | <input type="checkbox"/> visual disturbances |

Please list any other conditions/concerns in this pregnancy or past pregnancies:

Any other relevant information:

Consent for Treatment with Essence Wellness Clinic

I am hereby requesting **Acupuncture** **Massage** **Naturopathic** treatments from Essence Wellness Clinic. I have discussed any complications and concerns with my practitioner/therapist. New complications and concerns, if they do arise, will be discussed with my practitioner/therapist, and appropriate action will be taken. I understand that although these are natural and alternative treatments I am seeking, there may be risks of bruising, pain in treated area, and worsening of symptoms during the healing process. I hereby release Essence Wellness and all practitioners/therapists treating me from all liabilities.

I am also aware of the clinic's late cancellation policy of a charge of 50% of the visit cost if I fail to give less than 24 hours notice for cancellations. I understand that my extend health insurance will not be paying for such a charge and that I will be responsible to pay that charge before I can re-book.

Signature _____ Date _____
