Therapist: ____________________
Time: ____________________

☐ Couples Room

PRENATAL CLIENT INTAKE FORM

Name: ____ Date: _____/_____/_____

Age: ____________ Weeks of Pregnancy: ____________ Expected Due Date: _____/_____/_____

Physician: ______________________________ Phone: (________) ____________________

Emergency contact: ______________________ Phone: (________) ____________________

Please check any complication or condition you may have experienced in this pregnancy: (check all that apply)

_____*Multiple Pregnancy*
_____ *Phlebitis*
_____*High Blood Pressure*
_____*Headaches*
_____*Premature Labor*
_____*Constipation*
_____*Swollen Hands and/or Feet*
_____*Varicose Veins*
_____*Placental Dysfunction*
_____*Restless Legs*
_____*Threatened Miscarriage*
_____*Indigestion*
_____*Bladder Infection*
_____*Difficulty Sleeping*
_____*Gestational Diabetes*
_____*Leg Cramps*
_____*Pre-Eclampsia*
_____*Heartburn*
_____*Heart Disease*
_____*Hemorrhoids*
_____*Anemia*

List any current medications: ____

____ ______________________________
Client Signature **Date**

____ ______________________________
Therapist Signature **Date**