CHOICES PREGNANCY CARE CENTER

Patient Intake Form

Today's Date:	❑ Appointment ❑ Walk-in ❑ Time of Arrival:_____	**Gender:** ❑ Male ❑ Female	(Office Use Only) **Patient Number:** **Location:** ❑Gainesville ❑Flowery Branch

First Name:	**MI:**	**Last Name:**	**Birth Date:**	**Age:**

Address ❑ OK to mail	**City**	**County**	**State**	**Zip**

Phone #: ❑ OK to call and leave message ❑ Do not call	**Email:** ❑ OK to email ❑ Do not Email

Primary Language: ❑ English ❑ Spanish ❑ Other _____	**Race:** ❑ African American ❑ Asian ❑ Caucasian ❑ East Indian ❑ Hispanic ❑ Jewish ❑ Native American ❑ Other _____	**Occupation:**

Have you been to our clinic before? ❑ No ❑ Yes

How did you hear about us? (check one)

❑ Internet/Google ❑ Physician/Nurse ❑ Ad in paper ❑800# Hot Line
❑ Facebook ❑ Health Department ❑ Other Pregnancy Center ❑ Church
❑ School: Nurse, Counselor, Teacher, Coach **(please circle)** ❑ Friend/Relative ❑ Sign ❑ Flyer ❑Other _____

What outside help are you receiving? (check all that apply)

❑ Church ❑ Food Stamps ❑ Friends ❑ Husband/Wife
❑ Medicaid ❑ Other Pregnancy Center ❑ Parents ❑ WIC ❑Other_____

What are your living arrangements? (check all that apply)

❑ Alone ❑ Boyfriend/girlfriend ❑ Fiancé ❑ Father ❑ Mother ❑ Parents ❑ Friend
❑ Relatives ❑ Grandparents ❑ Child(ren) ❑ Spouse ❑Roommates ❑ Shelter ❑ Other _____

Marital Status: ❑ Married ❑ Engaged ❑ Divorced ❑ Separated ❑ Single ❑ Widowed	**Religion:** ❑ Atheist ❑ Buddhist ❑ Christian ❑ Catholic ❑ Hindu ❑ Jehovah's Witness ❑ Jewish ❑ Mormon ❑ Muslim / Islam ❑ None ❑ Sikhism ❑ WICCA ❑ Other _____	**Current Student Status:** ❑ Grad School ❑ College or University ❑ Trade School ❑High School ❑ Middle School ❑ Not a Student	**Highest Level of Education Completed** ❑ Grad School ❑ College or University ❑ High School/GED ❑ Middle School ❑ Trade School

Patient Number:

Pregnancy Intake/Request For Services Form

History:

1st Day of Last Menstrual Period: _____ Are you sure of the date? ❑ Yes ❑No

Was your last period normal? ❑ Yes ❑ No Are your periods regular?: ❑ Yes ❑ No

Symptoms (check all that apply):

□ Appetite Change □ Dizziness □ Frequent Urination □ Frequently Tired
□ Nausea □ Swollen or sore breasts □ Weight Gain or Loss □ Headaches
□ Vaginal Discharge □Vaginal Itching □Bleeding/spotting □Constipation □ Diarrhea □Swelling hands/feet
□Pain Location _____ Pain Level 1-10:_____
□ Other_____

Are you using birth control? ❑Yes ❑No If so, what kind? _____

Do you want to become pregnant? ❑Yes ❑No

Is this potential pregnancy due to rape or sexual abuse? ❑Yes ❑No

What is the potential father's name? _____ Age: _____

What is the potential father's relationship to you? _____

If the test is positive, will he be involved? ❑Yes ❑No ❑Unsure

Are you looking for a future with him? ❑Yes ❑No ❑Unsure

Does he know that you may be pregnant? ❑Yes ❑No ❑Unsure

If you have a positive pregnancy test, you are considering: ❑ Abortion ❑ Parenting ❑ Adoption ❑ Undecided

# of Previous Pregnancies: _____ # of Children: _____ Ages: _____

# of miscarriages _____ # of abortions _____ # of ectopic pregnancies _____

Did you complete a home pregnancy test? ❑ Yes ❑ No Result: ❑ Positive ❑ Negative ❑ Inconclusive

<u>Abortion Experience</u>

Of those pregnancies ending in abortion, what PHYSICAL side effects did you experience? (Select all that apply)
❑Cervical Damage ❑Hemorrhage ❑ Infection ❑Infertility ❑Future miscarriage ❑ Ruptured uterus
❑scarred endometrium ❑Other _____

Of those pregnancies ending in abortion, what EMOTONAL side effects did you experience? (Select all that apply)
❑Depression ❑Nightmares ❑Suicidal thoughts ❑Changed attitude towards God ❑Alcohol abuse ❑Drug abuse
❑Anniversary syndrome ❑Eating disorders ❑Relationship problems ❑Uncontrollable crying
❑Changed attitude towards children ❑ Flashbacks ❑Other_____

How do you feel now about your past abortion? (Select all that apply)
❑I think it was a good decision ❑I regret the decision ❑I have unresolved feelings about the decision
❑ I would like help dealing with a past abortion ❑I have received post-abortion counseling

Comments:_____

_____

_____

_____

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Reasons for coming here today (check all that apply):

❑ Pregnancy Test ❑ STD Testing (Circle all that apply) Chlamydia (Urine) Gonorrhea (Urine) HIV (Blood) Syphilis (Blood)

❑Ultrasound ❑ My Baby Counts ❑ Discuss Options ❑ Other: _____

Symptoms of STDs (Select all that apply):

❑Genital discharge ❑Genital odor ❑Genital Itching ❑ Pain with intercourse ❑Burning with urination ❑Fever

❑Genital sores//rashes ❑Pain in pelvis/lower abdomen ❑Other (please list) _____

How old were you when you became sexually active? _____ **Number of sexual partners:** _____

Are you currently sexually active with more than one partner? ❑**Yes** ❑**No**

Do you engage in homosexual practices? ❑**Yes** ❑**No**

Have you ever been a victim of abuse: ❑No **If Yes:** ❑Mental/Verbal ❑Physical ❑Rape/Sexual ❑Past ❑Present

Have you ever participated in an abortion decision? ❑Yes ❑No

Have you ever been tested for a sexually transmitted disease? ❑ Yes ❑ No **Date last tested?** _____

Have you ever tested positive for a sexually transmitted disease? ❑Yes ❑No **If so, which STD?**_____
When? _____

How many alcoholic drinks do you have per week?

How many packs of cigarettes do you smoke per week?

Do you use e-cigarettes/vapes? ❑**Yes** ❑**No**

Do you use any street drugs? ❑**Yes** ❑**No** **What type?**

Do you have medical insurance? ❑**Yes** ❑**No**

Do you have any allergies? ❑**Yes** ❑**No** **If yes, to what and what are your reactions?**

Are you currently on any type of medication? ❑**Yes** ❑**No** **List all medications and dosages:**

Please list a name and phone number of a pharmacy you would like to use if we have to call in a prescription for your treatment.

Pharmacy name: **Pharmacy Phone #:**

For your information:

Choice Pregnancy Care Center serves patients from a physical, emotional, mental and spiritual approach. You will be treated with respect at all times.

A positive pregnancy test is required for our medical files for all patients who are requesting an ultrasound. If you are here for an ultrasound or pregnancy options education, a urine pregnancy test will be conducted, free of charge.

Choices Pregnancy Care Center will hold in strict confidence all information provided, except under the following circumstances:
When there is a reasonable suspicion of child abuse, whether the patient is the victim or the abuser;
When there is a threat of self-inflicted harm; When there is reasonable suspicion of intimate partner violence;
When there is a threat of harm to a third party; When there is a threat against the clinic itself;
When information is necessary to be shared amongst staff involved in your care. To the extent required by Georgia State Law, we will make a report to the proper authorities in the instance of suspected abuse or threat of harm.

I have read and understand Choices' Services as stated above. Having been fully informed of the nature of the services offered. I willingly accept help and assistance from Choices Pregnancy Care Center.

Patient Signature:	**Date:**
Patient Representative or Legal Guardian Signature, if applicable:	**Date:**