

CHOICES PREGNANCY CARE CENTER

Patient Intake Form

Today's Date:		<input type="checkbox"/> Appointment <input type="checkbox"/> Walk-in	Gender:		(Office Use Only)
		<input type="checkbox"/> Time of Arrival: _____	<input type="checkbox"/> Female	Patient Number:	
			<input type="checkbox"/> Male	Location: <input type="checkbox"/> Gainesville	
				<input type="checkbox"/> Flowery Branch	
First Name:	MI:	Last Name:		Birth Date:	Age:
Address			City	County	State Zip
<input type="checkbox"/> OK to mail					
Phone #:		Email:			
<input type="checkbox"/> OK to call and leave message <input type="checkbox"/> Do not call		<input type="checkbox"/> OK to email <input type="checkbox"/> Do not Email			
Primary Language:		Race:			Occupation:
<input type="checkbox"/> English <input type="checkbox"/> Spanish		<input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> East Indian			
<input type="checkbox"/> Other _____		<input type="checkbox"/> Hispanic <input type="checkbox"/> Jewish <input type="checkbox"/> Native American <input type="checkbox"/> Other _____			
Have you been to our clinic before? <input type="checkbox"/> No <input type="checkbox"/> Yes					
How did you hear about us? (check one)					
<input type="checkbox"/> Internet/Google		<input type="checkbox"/> Physician/Nurse		<input type="checkbox"/> Ad in paper <input type="checkbox"/> 800# Hot Line	
<input type="checkbox"/> Facebook		<input type="checkbox"/> Health Department		<input type="checkbox"/> Other Pregnancy Center <input type="checkbox"/> Church	
<input type="checkbox"/> School: Nurse, Counselor, Teacher, Coach (please circle)		<input type="checkbox"/> Friend/Relative		<input type="checkbox"/> Sign <input type="checkbox"/> Flyer <input type="checkbox"/> Other _____	
What outside help are you receiving? (check all that apply)					
<input type="checkbox"/> Church		<input type="checkbox"/> Food Stamps		<input type="checkbox"/> Friends <input type="checkbox"/> Husband/Wife	
<input type="checkbox"/> Medicaid		<input type="checkbox"/> Other Pregnancy Center		<input type="checkbox"/> Parents <input type="checkbox"/> WIC <input type="checkbox"/> Other _____	
What are your living arrangements? (check all that apply)					
<input type="checkbox"/> Alone		<input type="checkbox"/> Boyfriend/girlfriend		<input type="checkbox"/> Fiancé <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Parents <input type="checkbox"/> Friend	
<input type="checkbox"/> Relatives		<input type="checkbox"/> Grandparents		<input type="checkbox"/> Child(ren) <input type="checkbox"/> Spouse <input type="checkbox"/> Roommates <input type="checkbox"/> Shelter <input type="checkbox"/> Other _____	
Marital Status:		Religion:		Current Student Status:	
<input type="checkbox"/> Married		<input type="checkbox"/> Atheist <input type="checkbox"/> Buddhist		<input type="checkbox"/> Grad School	
<input type="checkbox"/> Engaged		<input type="checkbox"/> Christian <input type="checkbox"/> Catholic		<input type="checkbox"/> College or University	
<input type="checkbox"/> Divorced		<input type="checkbox"/> Hindu <input type="checkbox"/> Jehovah's Witness		<input type="checkbox"/> Trade School	
<input type="checkbox"/> Separated		<input type="checkbox"/> Jewish <input type="checkbox"/> Mormon		<input type="checkbox"/> High School	
<input type="checkbox"/> Single		<input type="checkbox"/> Muslim / Islam <input type="checkbox"/> None		<input type="checkbox"/> Middle School	
<input type="checkbox"/> Widowed		<input type="checkbox"/> Sikhism <input type="checkbox"/> WICCA		<input type="checkbox"/> Not a Student	
		<input type="checkbox"/> Other _____			
Have you travelled outside of Georgia in the last 30 days? <input type="checkbox"/> Yes <input type="checkbox"/> No					If so, where did you travel?
Are you experiencing any flu-like symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If so, what symptoms?					

Pregnancy Intake/Request For Services Form**History:**1st Day of Last Menstrual Period: _____ Are you sure of the date? Yes NoWas 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 NoIs 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 UnsureAre you looking for a future with him? Yes No UnsureDoes he know that you may be pregnant? Yes No UnsureIf 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 InconclusiveAbortion Experience

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 EMOTIONAL 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):	
<input type="checkbox"/> Pregnancy Test <input type="checkbox"/> STD Testing (Circle all that apply) Chlamydia (Urine) Gonorrhea (Urine) HIV (Blood) Syphilis (Blood)	
<input type="checkbox"/> Ultrasound <input type="checkbox"/> My Baby Counts <input type="checkbox"/> Discuss Options <input type="checkbox"/> Other: _____	
Symptoms of STDs (Select all that apply):	
<input type="checkbox"/> Genital discharge <input type="checkbox"/> Genital odor <input type="checkbox"/> Genital Itching <input type="checkbox"/> Pain with intercourse <input type="checkbox"/> Burning with urination <input type="checkbox"/> Fever	
<input type="checkbox"/> Genital sores//rashes <input type="checkbox"/> Pain in pelvis/lower abdomen <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you engage in homosexual practices? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever been a victim of abuse: <input type="checkbox"/> No If Yes: <input type="checkbox"/> Mental/Verbal <input type="checkbox"/> Physical <input type="checkbox"/> Rape/Sexual <input type="checkbox"/> Past <input type="checkbox"/> Present	
Have you ever participated in an abortion decision? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever been tested for a sexually transmitted disease? <input type="checkbox"/> Yes <input type="checkbox"/> No Date last tested? _____	
Have you ever tested positive for a sexually transmitted disease? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you use any street drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No What type?	
Do you have medical insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have any allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, to what and what are your reactions?	
Are you currently on any type of medication? <input type="checkbox"/> Yes <input type="checkbox"/> 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:

Patient Number: