



Pregnancy and Babies Survey

FAX to 403.343.9580

Initial Intake – Prenatal Complete

**** Place Chart Label here OR complete the below information ****

Today's Date: _____

Doctor I am seeing today: _____

Patient Name: _____

My Family Doctor: _____

Phone Number: _____

Clinic of Family Doctor: _____

Email Address: _____

Location (town, city) of Clinic: _____

DOB: _____
(yyyy-mmm-dd)

I do not have a Family Doctor

My age is: 19 and under 20 - 39 40 and over

How many weeks pregnant 1 - 13 14 - 26 27 - 40+

Number of pregnancies I have had (including this one) _____

Number of children I have delivered _____

You may be contacted by the Primary Care Network to set up an appointment with a Pregnancy and Babies Nurse who provides information and resources over the telephone or in person.

If you would like to ensure that you receive a call, please check this box.

Concerns I have about this pregnancy

- | | |
|--|---|
| <input type="checkbox"/> Miscarriage/Premature Birth | <input type="checkbox"/> Safe Exercise |
| <input type="checkbox"/> Healthy weight gain | <input type="checkbox"/> Eating healthy |
| <input type="checkbox"/> Labour/Delivery | |
| <input type="checkbox"/> Other: _____ | |

Other things that concern me during this pregnancy

- | | |
|--|---|
| <input type="checkbox"/> Use of alcohol, medication or drugs | <input type="checkbox"/> Smoking (tobacco use) |
| <input type="checkbox"/> Previous traumatic birth/fears | <input type="checkbox"/> Moved to a new community |
| <input type="checkbox"/> Work/School | <input type="checkbox"/> Depression/Anxiety/Grief |
| <input type="checkbox"/> My Health (explain) _____ | |
| <input type="checkbox"/> Other: _____ | |

Concerns I have about support and relationships

- | | |
|---|---|
| <input type="checkbox"/> Relationship problems | <input type="checkbox"/> Single Parenting |
| <input type="checkbox"/> Stress at home | <input type="checkbox"/> Feeling Safe |
| <input type="checkbox"/> Support from family/friends/partner/father of baby | |

During the last year I was not able to afford

- | | |
|---|--|
| <input type="checkbox"/> Transportation | <input type="checkbox"/> Enough food |
| <input type="checkbox"/> Childcare | <input type="checkbox"/> Healthcare (dental, eye exam or prescription) |
| <input type="checkbox"/> Clothes | <input type="checkbox"/> Housing (mortgage or rent) |

Sometimes I may not get to my medical (doctor, lab, ultrasound) appointments because

- | | |
|---|---|
| <input type="checkbox"/> I feel uncomfortable or judged | <input type="checkbox"/> I do not feel it is a priority |
| <input type="checkbox"/> I have no one to watch my children | <input type="checkbox"/> I have no way to get there |
| <input type="checkbox"/> I cannot take time away from work/school | |

I am interested in the following Pregnancy related topics

- | | |
|---|---|
| <input type="checkbox"/> Feeding and caring for a newborn | <input type="checkbox"/> Routine tests and procedures |
| <input type="checkbox"/> Workplace Safety | <input type="checkbox"/> Stress Management |
| <input type="checkbox"/> Food Safety | <input type="checkbox"/> Dental Health |
| <input type="checkbox"/> Vaccinations | <input type="checkbox"/> My emotional /mental health |
| <input type="checkbox"/> Labour and Delivery/C-Section | <input type="checkbox"/> Managing common discomforts |
| <input type="checkbox"/> Other: _____ | |