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| Client Pregnancy Test IntakeThe Pregnancy Center of Sanford and Oviedo |

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| Client Name: | Date of Visit: |

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| 1. When was the first day of your last period? (mm/dd/yyyy) :  |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| 2. Was your last period normal?  Is it usually regular? Are you currently trying to become pregnant?❏ Yes ❏ No ❏ Unknown ❏ Yes ❏ No ❏ Unknown ❏ Yes ❏ No ❏ Unknown |
| 4. What symptoms are you having? (Check all that apply)

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| ❏ Appetite Change  | ❏ Dizziness  | ❏ Frequent Urination  | ❏ Frequently Tired  |
| ❏ Headache  | ❏ Moodiness  | ❏ Nausea  | ❏ No Period  |
| ❏ Other  | ❏ Swollen or sore breasts  | ❏ Vomiting  | ❏ Weight Gain or Loss  |

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| 5. Are you using Birth Control? (Check all that apply)

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| ❏ Condom  | ❏ Implant  | ❏ Natural Family Planning  | ❏ Other  |
| ❏ Depo-Provera  | ❏ IUD  | ❏ Norplant  | ❏ Pill  |
| ❏ Diaphragm  | ❏ Morning After Pill  | ❏ Ortho-Evra (Patch)  | ❏ Sterilization  |

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| 6. If your test is positive, what are your plans? ❏ Adoption   ❏ Parent   ❏ Terminate the Pregnancy (abortion) ❏ Undecided |
| 7. Are you having medical problems?  ❏ Yes   ❏ No       If yes, please list:  |
| 8. Are you suffering from any kind of illness?  ❏ Yes   ❏ No       If yes, please list:  |
| 9. Are you on any kind of medication?  ❏ Yes   ❏ No       If yes, please list:  |
| 10. Are you using drugs or alcohol?  ❏ Yes   ❏ No       If yes, please list:  |
| 11. Are you a cigarette smoker?  ❏ Yes   ❏ No  |
| 12. Are you experiencing any kind of stress?  ❏ Yes   ❏ No  |
| 13. Is this potential pregnancy due to rape or sexual abuse?  ❏ Yes   ❏ No  |
| 14. Do you feel safe in your current relationship? ❏ Yes   ❏ No Have you ever been affected by any kind of abuse?

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| ❏ Mental/Verbal  | ❏ Physical  | ❏ Rape  | ❏ Sexual  |  |  |

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|    |  Office Use Only |

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| *Data Entry: Pregnancy Test (Office Use Only)*  |
| 1. Staff/Volunteer Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(the person who met with the client) |
| 2. Test Result: ❏ Positive   ❏ Negative   Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Client Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_❏ \_\_\_\_\_\_ I have received a copy of the Negative Pregnancy Test Form (initial for negative test only).❏ \_\_\_\_\_\_ I have received a copy of the Verification of Pregnancy Form.  |
| 3. Estimated Due Date (mm/dd/yyyy): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weeks of Gestation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 4. Type of Test: ❏ Initial Test   ❏ Retest    |