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| Client Pregnancy Test Intake  The 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) : |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| 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)   |  |  |  |  | | --- | --- | --- | --- | | ❏ Appetite Change | ❏ Dizziness | ❏ Frequent Urination | ❏ Frequently Tired | | ❏ Headache | ❏ Moodiness | ❏ Nausea | ❏ No Period | | ❏ Other | ❏ Swollen or sore breasts | ❏ Vomiting | ❏ Weight Gain or Loss | |
| 5. Are you using Birth Control? (Check all that apply)   |  |  |  |  | | --- | --- | --- | --- | | ❏ Condom | ❏ Implant | ❏ Natural Family Planning | ❏ Other | | ❏ Depo-Provera | ❏ IUD | ❏ Norplant | ❏ Pill | | ❏ Diaphragm | ❏ Morning After Pill | ❏ Ortho-Evra (Patch) | ❏ Sterilization | |
| 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?   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | ❏ Mental/Verbal | ❏ Physical | ❏ Rape | ❏ Sexual |  |  | |

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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 |