

*Inside Passage
Midwifery and Natural Medicine, LLC*

Client Information/Registration

Date: _____ Social Security Number: _____
Name: First _____ Middle. _____ Last: _____
Physical address: _____
Mailing Address: _____
Home Phone: _____ Cell/other phone: _____
Birth date: _____ Marital Status: _____ Email address: _____
Employer: _____ Occupation: _____
Spouse/Partner's Name: _____ Occupation: _____
Emergency Contact: _____ Phone: _____

Responsible Party (Primary insurance policy holder. If same as above leave blank)

First Name: _____ M.I. _____ Last Name: _____
Address: _____
Home Phone: _____ Birth date: _____ Marital Status: S M D W
Social Security Number: _____ Employer: _____
Occupation: _____
Work Status: Full _____ Part time _____ Retired _____ Student _____

Payment and Insurance Information

Primary Insurance: _____
Address: _____
Phone Number: _____
ID#: _____ Group Name: _____ Group #: _____
Policy Holder: _____ Birth date: _____ Relation: _____

Other Insurance: _____
Address: _____
Phone number: _____
ID#: _____ Group Name: _____ Group #: _____
Policy Holder: _____ Birth date: _____ Relation: _____

Assignment of Benefits, Release of Information & Payment Agreement

I understand that payment is due at the time of service unless other arrangements have been made. I understand that Inside Passage Midwifery and Natural Medicine will be filing my insurance on my behalf. I agree to have the benefits from my insurance assigned to Inside Passage Midwifery.

I permit Inside Passage to release any information deemed necessary to any insurance or third party, within the guidelines of HIPAA (Health Insurance Portability & Accountability Act)

I agree that I am responsible for full payment on this account.

Client signature: _____ Date: _____

Responsible Party (if different): _____ Date: _____

Inside Passage Midwifery

Name: _____ Date: _____

What was the first day of your last menstrual period? _____

Are you sure of the date? _____

Was your period normal in length and flow? _____

Are your cycles regular? _____

How many days in your cycle? _____

How many days do you normally bleed? _____

Date of positive pregnancy test: _____

What day do you think you conceived? _____

Is this a planned pregnancy? _____

Most recent birth control used: _____

Past Contraception: type, when, any problems: _____

Previous Pregnancies:

Total number of past pregnancies _____

Full term deliveries: _____

Premature deliveries: _____

Miscarriages: _____

Therapeutic Abortions: _____

Cesarean section: _____

Twins: _____

Number of living children: _____

	1	2	3	4
Name of child				
Date of birth				
Boy or Girl?				
Weight at birth				
Home/hospital/birth center				
Length of labor				
Anesthesia/medications				
Episiotomy or tears?				
Breastfed? How long?				
Any Complications? High blood pressure, pre-eclampsia, shoulder dystocia, hemorrhage, retained placenta, Problems with baby or breastfeeding, etc.				

Name: _____

Date: _____

Medical History

Please mark if you have any of the following conditions. In the space below record date, treatment and any follow-up care received. Also feel free to list any other conditions or concerns:

____ Endocrine: diabetes, disorders involving thyroid, adrenal, pituitary or parathyroid glands, etc.

____ Cardiovascular: high blood pressure, heart or valve problems, chest pain, etc.

____ Gastrointestinal: abdominal pain, constipation, colitis, GERD/reflux, ulcers, etc

____ Genitourinary: bladder infections, kidney infections, kidney stones, etc,

____ Hematological: anemia, bleeding disorders, blood transfusions, thrombophlebitis, Rh disease. etc.

____ Musculoskeletal: fractures, neck problems, back problems, scoliosis, injuries, arthritis, fibromyalgia

____ Pulmonary: asthma, cough, pneumonia, pulmonary embolism, tuberculosis, etc.

____ Neurological: epilepsy, seizure, strokes, neuropathy, headaches, head injury, etc.

____ Autoimmune: lupus, multiple sclerosis, rheumatoid arthritis, celiac disease, etc

____ Dermatological: eczema, allergy, psoriasis, warts, skin tags, etc.

____ Mental/Emotional: depression, anxiety, eating disorders, addictions, postpartum depression, etc.

____ Other: accidents, surgery, significant illness, domestic violence, etc.

Gynecologic History:

How old were you when you had your first menstrual period? _____

When was your last Pap? _____

Have you ever had an abnormal Pap? _____

If yes please explain _____

Please check if you've ever had any of the following conditions or procedures:

<input type="checkbox"/>	Yeast infection	<input type="checkbox"/>	Pelvic Inflammatory disease	<input type="checkbox"/>	Uterine fibroids
<input type="checkbox"/>	Bacterial vaginosis	<input type="checkbox"/>	Cervicitis	<input type="checkbox"/>	Uterine surgery
<input type="checkbox"/>	Chlamydia	<input type="checkbox"/>	Cervical polyps	<input type="checkbox"/>	Breast lumps
<input type="checkbox"/>	Gonorrhea	<input type="checkbox"/>	Ovarian cysts	<input type="checkbox"/>	Breast surgery
<input type="checkbox"/>	Syphilis	<input type="checkbox"/>	Polycystic ovarian syndrome, PCOS	<input type="checkbox"/>	Repeated miscarriage
<input type="checkbox"/>	Trichomonas	<input type="checkbox"/>	Endometriosis	<input type="checkbox"/>	Infertility
<input type="checkbox"/>	Genital herpes	<input type="checkbox"/>	Abnormal bleeding	<input type="checkbox"/>	Other
<input type="checkbox"/>	Genital warts	<input type="checkbox"/>	Cervical surgery/LEEP	<input type="checkbox"/>	
<input type="checkbox"/>	Group B strep	<input type="checkbox"/>	HPV: human papilloma virus	<input type="checkbox"/>	

Name: _____

Date: _____

Allergies

Do you have any allergies to medications or foods? _____

Surgical History: Please list any past surgical procedures and dates:

Family History

Father: Alive and well? Y N If no explain: _____

Mother: Alive and well? Y N If no explain: _____

How many pregnancies did your mother have? _____ How many miscarriages? _____

How many times did she give birth? _____ Did she have any C-sections? _____

Siblings: Alive and well? Y N If no explain _____

Please check if you have a family history of the following conditions:

_____ Diabetes _____	_____ Twins _____
_____ Hypertension _____	_____ Down's syndrome _____
_____ Cancer _____	_____ Genetic Disorders _____
_____ Blood Disorder _____	_____ Cystic Fibrosis _____
_____ Congenital Anomalies _____	_____ Neural Tube defects _____

Current Pregnancy Problems and Exposures:

Please check if you've had any of these problems in this pregnancy

Nausea	Constipation	Anemia	Backache	Depression
Vomiting	Hemorrhoids	Fatigue	Sciatic nerve pain	Anxiety
Vaginal bleeding	Varicose veins	Weakness	Leg cramps	Relationship issues
Uterine cramping	Diarrhea	Fainting	Swelling	Family issues
Bladder infection	Heartburn	Vaginal discharge	Headache	Work issues
Kidney infection	Poor appetite	Vaginal infection	Dizziness	Difficulty sleeping
Fever	Indigestion	Pelvic pain	Breast pain	Other

Have you used or been exposed to any of the following during this pregnancy?

Prenatal vitamins	Nutritional supplements	Marijuana	Ultrasound
Prescription Medication	Caffeine	Street drugs: cocaine, oxycontin, methamphetamine, etc.	Chemicals, fumes, sprays
Over the counter medications	Alcohol	Vaccinations	Cat litter
Herbal Medicines	Tobacco	X-rays	Other

Name: _____

Date: _____

Y N – Have you had a previous baby with birth defect or mental retardation?

Y N - Do you have a history of genetic or inherited conditions or genetic counseling?

Y N – Do you have a history of hepatitis?

Y N – Do you have a history of IV drug use or blood transfusion?

Y N – Do you have a history of a sexual partner who used IV drugs, had bisexual relations or blood transfusions?

Y N – Have you had a history of anorexia, bulimia or other eating disorder?

Y N – Have you ever been in an abusive relationship, including now, or been abused – physically, emotionally, sexually

Do you know where you plan to give birth? Home, hospital, birth center?

If no, what information or support do you need to help you in making this decision?

How do you feel about this pregnancy?

How does your partner feel about this pregnancy?

Are there any particular ethnic, cultural or religious preferences for your care that you'd like to discuss?

Do you feel you have adequate resources for this pregnancy, i.e. food, shelter, money?

Why did you choose to see me?

What expectations do you have of me professionally as your midwife?

Name: _____

Date: _____

What expectations do you have of me personally as your midwife?

What is your present level of commitment to address any lifestyle issues that may relate to your pregnancy?
Rate from 0 to 10, 10 being 100% committed

0% 0 1 2 3 4 5 6 7 8 9 10 100%

What behavior or lifestyle habits do you currently engage in regularly that you believe are detrimental to your pregnancy?

Do you feel you have people in your life that will sincerely and consistently support you during this pregnancy?

Many people seek midwifery care because they believe pregnancy and birth to be a normal natural process. As a naturopathic doctor I have knowledge of various nutrients, herbs and homeopathic remedies that may be helpful and supportive of your pregnancy and birth. Would you be interested in suggestions or taking additional supplements during your pregnancy?

Thank you for taking the time to complete these many forms. I look forward to providing you with the best possible care. If there is anything else you would like to add at this time please do so here.

*Inside Passage Midwifery
800 Glacier Ave, Suite 100
Juneau, AK 99801*