SACRAMENTO LIFE CENTER
Patient Intake – Pregnancy

Official Use Only	Official Use Only	Official Use Only
Time Out ID Verification Done Pt. Name: ☐ Pt. DOB: ☐ Your Initials: _____	Patient is at risk for falls YES ☐ Form completed NO ☐ Your Initials: _____	DVS YES ☐ NO ☐ Your Initials: _____

❑ Sacramento Clinic ❑ Mobile Clinic

Date of Visit:	Type of Visit: ❑ New ❑ Return	What is the primary reason for this visit? ❑ Pregnancy testing ❑ Other _____
First Name:	Last Name:	MI:
Mailing Address:	City:	State: / Zip:
Phone:	May we leave a message? ❑ Yes ❑ No	
Is it OK for us to contact you? (Check all that apply) ❑ By Phone ❑ By Mail ❑ By Email /Text ❑ No	If ok to contact by email, please provide current email: Email:	
Date of Birth: Age:	Insurance Coverage: ❑ Medi-Cal ❑ Private: _____ ❑ None	Race: ❑ African American ❑ Asian ❑ Caucasian ❑ East Indian ❑ Haitian ❑ Hispanic ❑ Native American ❑ Pacific Islander ❑ Other _____
Income: ❑ Employed ❑ Unemployed ❑ Dependent Source: ❑ Self ❑ TANF/SSI ❑ Parents		I live with: ❑ Alone ❑ Homeless ❑ Spouse ❑ Boy / Girl friend ❑ Parent(s) ❑ Other _____ ❑ Children ❑ Roommate ❑ Fiancé ❑ Shelter
Occupation or Job Title: Place of Employment: School Attending:		Marital Status: ❑ Single ❑ Engaged ❑ Married ❑ Live Together ❑ Separated ❑ Divorced
Student Status: ❑ Middle School or Jr. High ❑ High School ❑ College or University ❑ Not Student ❑ Trade School/Other		Religious Denomination: _____ Would you like a referral to local organizations that can provide help with your spiritual needs? ❑ Yes ❑ No

Have you ever been to Sacramento Life Center before? ❑ Yes ❑ No

❑ Same Name Other name? _____

How did you hear about us?

_____

Patient Intake - Pt. 2

Patient Name:	Date of Birth:	Date of Visit:

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

2. Was your last period normal?
❑ Yes ❑ No ❑ Unknown

3. Is your period (menstrual cycle) regular?
❑ Yes ❑ No ❑ Unknown

4. What (pregnancy) symptoms are you having? (Check all that apply)
❑ Appetite Change ❑ Dizziness ❑ Frequent Urination ❑ Frequently Tired
❑ Nausea ❑ Swollen or sore breasts ❑ Weight Gain or Loss

5. Are you using Birth Control? (Check all that apply)
❑ Condom ❑ Depo-Provera ❑ Diaphragm ❑ None ❑ Foam/Gel
❑ IUD ❑ Morning After Pill ❑ Natural Family Planning (Rhythm Method) ❑ Norplant
❑ Ortho-Evra (Patch) ❑ Other ❑ Pill ❑ Sterilization

6. If you are not using Birth Control, did you want to get pregnant? ❑ Yes ❑ No ❑ Undecided

7. Total # of previous pregnancies: _____ Outcomes: Live Birth- ____ Abortion- ____ Miscarriage- ____ Adoption- ____ Stillbirth-____

8. Are you having medical problems? ❑ Yes ❑ No If yes, please list:

9. Are you suffering from any kind of illness? ❑ Yes ❑ No If yes, please list:

10. Are you concerned about STD exposure? ❑ Yes ❑ No If yes would you like information on testing? ❑ Yes ❑ No

11. Are you on any kind of medication? ❑ Yes ❑ No If yes, please list with dosages:

12. Do you have allergies? ❑ Yes ❑ No If yes, please list with reactions:

13. Are you using drugs or alcohol? ❑ Yes ❑ No If yes, please list:

14. Are you a cigarette smoker? ❑ Yes ❑ No

15. Are you experiencing any kind of stress? ❑ Yes ❑ No

16. Is this potential pregnancy due to rape or sexual abuse? ❑ Yes ❑ No

17. If your test is positive, what are your intentions? ❑ Abort ❑ Carry to Term ❑ Undecided ❑ N/A

18. If you plan to carry to term, what are your intentions? ❑ Adoption ❑ Parent ❑ Undecided

19. What is the potential father's name? _____ Age? _____

20. If the test is positive, will he be involved? ❑ Yes ❑ No ❑ Unsure

21. Are you looking for a future with him? ❑ Yes ❑ No ❑ Unsure

22. Does he know that you might be pregnant? ❑ Yes ❑ No ❑ Unsure

23. What is his relationship to you? _____

_____ ____/____/____
Patient Signature Date

_____ ____/____/____
Reviewed By Sacramento Life Center Medical or PA Staff-Signature Date