ground floor health
NATURAL MEDICINE

MIDWIFERY CLIENT REGISTRATION

Name: First Middle Last Maiden?				Date	Phone (home) (work)
Race/Ethnicity	Yrs Educ	Married?	Occupation And Type of Industry	Date of Birth	State of Birth
Address: Street City Zip County				Inside City Limits? _____Yes _____No	How long at this address?
Father of Baby Name: First Middle Last			Race	Yrs Educ	Date of Birth / State of Birth
Address (if different from above)				Phone (home) (work)	Occupation and Type of Industry
Partner/Husband (if different from the Father of Baby)			Emergency Contact Name: Phone: Relationship:		
Method of Payment: _____Medicaid _____Cash _____Insurance ____Other			Insurance Information: Co-pay_____ Name of Policy Holder:_____ Policy#: Group #:		
Mother's Social Security Number (SSN)	Father's SSN		SSN Requested for baby ___Yes ___No	Referred by:	

FAMILY HISTORY—Indicate if anyone in your immediate family has ever had any of these, who; when.

- ❑ High blood pressure_____
- ❑ Cancer_____
- ❑ Diabetes_____
- ❑ Twins_____
- ❑ Severe emotional problems___
- ❑ Alcohol/drug abuse_____
- ❑ Other_____

FATHER OF BABY—Indicate if the baby's father has ever had any of these; when.

- ❑ Sexually transmitted diseases_
- ❑ Herpes: GENITAL or ORAL (circle one)_____
- ❑ Severe emotional problems___
- ❑ Alcohol/drug abuse_____
- ❑ Tobacco use_____
- ❑ Other_____

YOUR MOTHER'S HISTORY—Answer the following regarding your mother.

- ❑ # of pregnancies_____
- ❑ # of births_____
- ❑ Miscarriages_____
- ❑ Any complications_____
- ❑ Your weight at birth_____
- ❑ Did she take DES with you? YES or NO (circle one)

PREVIOUS PREGNANCY OUTCOMES *Please complete this table regarding your own pregnancies (earliest to most recent)*

Date	# Weeks	Birth/Miscarriage/Termination	Comment/Problems

\Yes No Have you or the father of the baby (FOB) ever had a baby with a birth defect or mental retardation?

Yes No Do you or the FOB have any family members with birth defects or conditions diagnosed as genetic or inherited?

Yes No Are you and the FOB related by blood? (i.e. cousins)

Yes No Are you or the FOB from any of these ethnic/racial groups? (circle)
JEWISH BLACK/AFRICAN ASIAN MEDITERRANEAN

Yes No Have you or the FOB ever had hepatitis or jaundice?

Yes No Have you ever used any drug intravenously (IV) or had a blood transfusion?

Yes No Have you ever had a sexual partner who used any drug IV, had a blood transfusion, or had bisexual relations?

Yes No Do you think you are at increased risk for having a baby with a birth defect or genetic problem?

Yes No Do you think you are at increased risk for AIDS/HIV?

Yes No Have you ever experienced dramatic fluctuations in your weight?

Yes No Have you ever had anorexia, bulimia, or other eating problems?

Yes No Is there anything about the development of your sexuality that you'd like to discuss?

Yes No Have you ever been in an abusive relationship, including now, or been abused (physically or emotionally intimidated, beaten, injured, or made to take part in sexual activities against your will).

Yes No Have you ever had severe emotional problems?

Yes No Have you ever been on any medication for psychological problems?

Yes No Has anyone ever told you, or do you think, you have ever used alcohol or drugs excessively?

NAME: _____ DATE OF BIRTH:_____

MEDICAL HISTORY: Please indicate if you have ever had any of these and when:

- ❑ Severe headaches__
- ❑ Eye/vision problems_
- ❑ Ear/hearing problems
- ❑ Dental problems____
- ❑ Thyroid problems___
- ❑ Rheumatic fever____
- ❑ Blood clotting prob.__
- ❑ Anemia_____
- ❑ Hemorrhage_____
- ❑ High blood pressure_
- ❑ Varicose veins_____
- ❑ Hemorrhoids_____
- ❑ Tuberculosis_____
- ❑ Asthma_____
- ❑ Skin disorders_____
- ❑ Stomach problems__
- ❑ Ulcers_____
- ❑ Chicken pox_____
- ❑ Bowel problems____
- ❑ Blood in stool_____
- ❑ Gall bladder prob.___
- ❑ Liver problems_____
- ❑ Hepatitis_____
- ❑ Diabetes_____
- ❑ Hypoglycemia_____
- ❑ Bladder infection____
- ❑ Kidney infection____
- ❑ Urinary surgery_____
- ❑ Urethral dilation____
- ❑ Aching joints_____
- ❑ Pelvic/back injuries__
- ❑ Seizures_____
- ❑ Cancer_____
- ❑ Hospitalizations____
- ❑ Surgeries_____
- ❑ Other_____

ALLERGIES:

Do you have any allergies? ___Yes ___No

Please list:_____

_____

_____

GYNECOLOGIC HISTORY

Age at first period_____ Cycle length (days)_____

Regular? ___Yes ___No; Duration (days) _____

When was your last Pap? _____

Ever abnormal Pap? ___Yes ___No; Dates: _____

Please indicate if you have ever had any of the following gynecological conditions and when:

- ❑ Yeast_____
- ❑ Trichomonas_____
- ❑ Group B Strept_____
- ❑ Bacterial Vaginosis__
- ❑ Chlamydia_____
- ❑ Gonorrhea_____
- ❑ Syphilis_____
- ❑ PID/Pelvic infection__
- ❑ Genital sores_____
- ❑ Herpes:_____ ___Genital ___Oral
- ❑ Genital warts_____
- ❑ Cervicitis_____
- ❑ Cervical surgery____
- ❑ Cervical polyp_____
- ❑ Ovarian cyst_____
- ❑ Fibroids_____
- ❑ Endometriosis_____
- ❑ Abnormal bleeding__
- ❑ Uterine surgery_____
- ❑ Breast lump(s)_____
- ❑ Breast surgery_____
- ❑ Infertility_____
- ❑ Other_____

PRESENT PREGNANCY

Last menstrual period (1st day)_____

Was it a normal period? ___Yes ___No

Suspected date of conception: _____

Positive pregnancy test date: _____

Planned pregnancy? ___Yes ___No

Feelings about pregnancy _____

Father's/Partner's feelings _____

Most recent birth control used _____

Contraception used in past: what, when, any problems?

_____

Please indicate if you've had any of the following problems during this pregnancy:

- ❑ Nausea
- ❑ Vomiting
- ❑ Fever
- ❑ Infections
- ❑ Headache
- ❑ Dizziness
- ❑ Indigestion
- ❑ Leg cramps
- ❑ Rash
- ❑ Backache
- ❑ Swelling
- ❑ Constipation
- ❑ Diarrhea
- ❑ Urinary complaints
- ❑ Gut or pelvic pain
- ❑ Vaginal bleeding
- ❑ Vaginal discharge
- ❑ Bleeding gums
- ❑ Varicose veins
- ❑ Hemorrhoids
- ❑ Depression
- ❑ Loneliness
- ❑ Family/relationship problems
- ❑ Work problems
- ❑ Other

Please indicate if you have used, experienced, or been exposed to any of the following during this pregnancy:

- ❑ Tobacco
- ❑ Alcohol
- ❑ Caffeine
- ❑ Marijuana
- ❑ Cocaine
- ❑ Street drugs
- ❑ Other meds
- ❑ Non-pres. Drugs
- ❑ Vitamins
- ❑ Herbs
- ❑ Fumes/sprays
- ❑ X-rays
- ❑ Ultrasound
- ❑ Measles/viruses
- ❑ Travel
- ❑ Vaccinations
- ❑ Cats
- ❑ Other

Planned place of birth :

____Home ____Birth Center ____Hospital

If home, please indicate if you have:

____Water ____Electricity ____Telephone

Are there any particular ethnic, cultural, or religious preferences for your care during pregnancy and birth that you would like to discuss? _____

ground floor health
NATURAL MEDICINE

Midwifery Informed Consent

While the course of childbearing is a normal human function, it has been explained and I understand that although the likelihood is small in "low risk" women, in any particular case medical complications can arise unpredictably and suddenly. In such cases, mother and/or baby may be at greater risk being outside a hospital setting. I understand that there are also risks associated with labor and birth in a hospital setting. I have made an informed choice regarding the place of birth of my child. I understand that Christina Gutierrez, naturopathic midwife (ND, LM) and Sarah Ambrose, midwife (LM) carry certain emergency equipment but cannot duplicate all services available in the hospital setting. I understand that Christina Gutierrez, ND, LM and Sarah Ambrose LM do not employ electronic fetal monitoring, perform Cesarean sections, or administer blood transfusions.

I understand that the practice of medicine, nursing, and midwifery are not exact sciences, and I acknowledge that no guarantees can be made to me concerning results of treatments, exams, and procedures to be performed. I have the assurance that all information regarding my care while a client of Christina Gutierrez ND, LM and Sarah Ambrose LM will be shared with me. In addition, decisions regarding my care will be made in consultation with me. I am aware that Christina Gutierrez, ND, LM and Sarah Ambrose LM carry malpractice insurance.

I further understand that a naturopathic midwife functions under two licenses. The naturopathic license allows her to diagnose and treat disease, whereas the midwifery license allows for the care of normal pregnancy and birth.

In view of above, I understand that in the selection and treatment of women, Christina Gutierrez ND, LM and Sarah Ambrose LM will rely on my medical history and information about myself which I provide. I affirm that such information is and will be complete, correct, and accurate to the best of my knowledge. In addition, I understand that development of any of the following conditions during my pregnancy could be potentially dangerous for me and/or my baby. I agree to inform Christina Gutierrez, ND, LM and Sarah Ambrose LM if I detect any of the following during pregnancy:

- Vaginal bleeding
- Severe or continued nausea and vomiting
- Continued severe headaches
- Unusual or sudden swelling or puffiness
- Blurred vision or spots before the eyes
- Pain or burning on urination
- Chills and/or fever
- Sharp or continuous abdominal pain
- Sudden gush of water or leaking of fluid from the vagina
- Sudden or unusual decrease in the movement of the baby

I have had an opportunity to inform myself or be informed regarding the complications that could arise. My midwife informed me during the consultation visits of a list of potential medical complications that require referral. I agree to assume the risks associated with childbirth out-of-hospital. I am responsible for making informed choices, and asking questions to clarify issues about my own, and my baby's health. I am also expected to follow-through with recommendations, treatments, and office visits as indicated.

I authorize Christina Gutierrez ND, LM and Sarah Ambrose LM to treat me and my baby and when necessary in an emergency, to take appropriate measures or transfer me, or my baby, to a medical physician or hospital for care.

Signature of client	Date
Signature of spouse or partner (optional)	Date