Andrea L. Herrst DC
319 SW Washington St Ste 1001
Portland OR 97204

City Fit Family Chiropractic Center LLC
ph 503-224-5010 fax 503-248-5626
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PostPartum Intake Form:

In order to provide you the best possible care, please inform us at each visit of any changes in your health or contact information.

Patient Name: _____ Today's Date: _____
Patient's Date of Birth: _____ Delivery Date: _____

Health History:
Please check any box that applies to your current or past history:

Current	Past	
☐	☐	Vericose veins/hemorrhoids
☐	☐	Blood clot
☐	☐	Twins or other multiples
☐	☐	Preeclampsia/HELLP syndrome
☐	☐	High blood pressure
☐	☐	Pre-term birth
☐	☐	Miscarriage
☐	☐	Visual disturbances
☐	☐	Abdominal cramping
☐	☐	IUD in place
☐	☐	Sciatica/Hip pain
☐	☐	Diabetes (*ciricle:* Mellitus or Gestational)
☐	☐	Separation of abdominal muscles (diastasis recti)
☐	☐	Separation of pubic bone/ SPD
☐	☐	Broken/misplaced tailbone
☐	☐	Anemia
☐	☐	Hemmorrhage
☐	☐	Bleeding (uterine or vaginal)
☐	☐	Pain (*where*): _____
☐	☐	Fatigue/Exhaustion/lack of sleep
☐	☐	Blood thinners
☐	☐	Uterine, Bladder, Rectal Prolapse
☐	☐	Urinary/fecal incontience
☐	☐	Nerve pain

Is there anything else you would like us to know?
_____
_____
_____
_____.

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Labor and Delivery:

Where did you give birth:_____
Did things go close to what you had planned/expected?_____.
Any complications with childbirth? _____No _____ Yes (what):_____
_____

Birth related surgeries or interventions *(circle):* C-section, tubal ligation, laceration, episiotomy, perineal stitches, retained placenta, vacuum extraction, forceps, other _____.

Are you healed/healing/having pain/confused regarding your labor/delivery?

Did you have an epidural or other anesthesia (which) No_____ Yes _____.
Any pain related to that? ____ No ____ Yes _____.

Date of most recent visit to postnatal care provider: _____.

Do any of these words describe your postpartum experience so far (*circle):* overwhelmed / have the blues / ecstatic / concerned / isolated / well-supported / cared for / lonely / happy / curious / surprised / in pain / scared / content / lost / sad / irritable / attuned / committed / other: _____.

Please circle which, if any of the health conditions below you are experiencing:

Recent injury or illness: _____
Allergies: _____
Chronic pain or chronic illness: _____
Joint problems: _____
Kidney problems: _____
Contagious skin disorders:_____
Cancer or undiagnosed growths:_____
Currently taking medication: _____

It is my choice to receive chiropractic treatment and/or massage therapy. I will communicate with Dr. Andrea L. Herrst DC, Brittany Newcomb LMT CA, Emma Morehouse LMT CA, or any other provider employed at City Fit Family Chiropractic Center LLC about any discomforts or preferences I have about my treatment. I have stated all personal medical conditions that I am aware of and will update my provider of any changes in my health status.

I have further questions to ask the treating provider: ___ No ___ Yes
Signature:_____
Date: _____

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Edinburgh Postnatal Depression Scale*

As you are pregnant or have recently had a baby, we would like to know how you are feeling. The EPDS is only a screening tool. It does not diagnose depression. Please check the answer that comes closest to how you have felt in **the past 7 days**, not just how you feel today.

In the past 7 days:

I have been able to laugh and see the funny side of things ◯ As much as I always could ◯ Not quite so much now ◯ Definitely not so much now ◯ Not at all	**Things have been getting on top of me** ◯ Yes, most of the time I haven't been able to cope at all ◯ Yes, sometimes I haven't been coping as well as usual ◯ No, most of the time I have coped quite well ◯ No, I have been coping as well as ever
I have looked forward with enjoyment to things ◯ As much as I ever did ◯ Rather less than I used to ◯ Definitely less than I used to ◯ Hardly at all	**I have been so unhappy that I have had difficulty sleeping** ◯ Yes, most of the time ◯ Yes, some of the time ◯ Not very often ◯ No, not at all
I have blamed myself unnecessarily when things went wrong ◯ Yes, most of the time ◯ Yes, some of the time ◯ Not very often ◯ No, never	**I have felt sad or miserable** ◯ Yes, most of the time ◯ Yes, some of the time ◯ Not very often ◯ No, not at all
I have been anxious or worried for no good reason ◯ No, not at all ◯ Hardly ever ◯ Yes, sometimes ◯ Yes, very often	**I have been so unhappy that I have been crying** ◯ Yes, most of the time ◯ Yes, quite often ◯ Only occasionally ◯ No, never
I have felt scared or panicky for no good reason ◯ Yes, quite a lot ◯ Yes, sometimes ◯ No, not much ◯ No, not at all	**The thought of harming myself has occurred to me** ◯ Yes, quite often ◯ Sometimes ◯ Hardly ever ◯ Never

Score:_____

Patient signature:_____Administered/Reviewed by:_____

*Source: Cox,J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786