Andrea L. Herrst DC
510 SW 3rd Ave, Suite 210
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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, Lisa Jewell DC or any other provider 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