SLO Family Acupuncture

2066 Chorro St ♦ San Luis Obispo, CA 93401
(805) 242-6852 ♦ www.slofamilyacupuncture.com

Baby's Name _____ Baby's Age _____ Sex: M F

Date of delivery _____ Vaginal birth or C-section _____

How many week's pregnant at delivery? _____ Baby's weight at birth _____

Midwife or Doctor's Name who did delivery _____

Are you still under the care of the same Midwife/Doctor? ❑ Yes ❑ No

If not, please list new Midwife/Doctor's name _____

Do you have a lactation consultant? ❑ Yes ❑ No Name _____

Was your labor medically induced? ❑ Yes ❑ No

If so, what technique was used? _____

In general, how was the delivery? _____

_____

_____

Were there any complications or trauma? ❑ Yes ❑ No

If so, please provide details: _____

_____

_____

Was there any medical intervention? ❑ Yes ❑ No What type? _____

Please list any medications, including pitocin and epidurals, which were given to you during labor/delivery and the reason why they were given: _____

_____

_____

Was there any tearing? ❑ Yes ❑ No

Was an episiotomy performed? ❑ Yes ❑ No

Was there any hemorrhaging? ❑ Yes ❑ No

Are you currently bleeding? ❑ Yes ❑ No

How many weeks did you experience postpartum bleeding? _____

Are you currently breastfeeding? ❑ Yes ❑ No

How many times per day? _____ How many times per night? _____

Thank you for taking the time to complete this intake form. I look forward to working with you.
–Carla Nerelli, L.Ac

Have you had any complications with breastfeeding? ❑ Yes ❑ No

If so, please describe: _____

_____

Is your baby experiencing any digestive upset? ❑ Yes ❑ No

Does your baby have colic? ❑ Yes ❑ No

Does your baby have any food allergies? ❑ Yes ❑ No To what:_____

Does your baby have cradle cap, diaper rash, or thrush? ❑ Yes ❑ No

Please circle any of the following symptoms you have had, or are currently experiencing, in association with your postpartum recovery:

Body aches and pain	*Constipation*	*Fatigue*	*Uterine Prolapse*
Healing from incisions	*Mastitis*	*Headache*	*Urinary Difficulties*
Persistent Lochia	*Sweating*	*Hemorrhoids*	*Crying for no reason*
Low back pain	*Neck and shoulder pain or tension*		

How many times have you given birth prior to this experience?_____

How are you feeling emotionally? _____

_____

_____

Have you experienced postpartum depression with any previous children? ❑ Yes ❑ No

Do you have a strong support system? ❑ Yes ❑ No

Thank you for taking the time to complete this intake form. I look forward to working with you.
–Carla Nerelli, L.Ac