WHOLE PERSON HEALING
INTEGRATIVE PREGNANCY & PERINATAL CARE
Dr. Deanine Picciano AP, LMT

Date: _____
Name: _____ Birthday:_____
Address:_____
City:_____ State:____ Zip:_____
Phone Numbers: (C)_____(H)_____
Emergency Contact & Phone #:_____
Email:_____
Do you have Insurance: __Yes __No
Does it cover Massage: __Yes __No __ Unsure, Please check
Name of primary OB/GYN Midwife handling your care:
_____
What is your due date: _____
How many weeks pregnant are you today? _____
Do currently have any complications or medical issues with your pregnancy? No / Yes If yes, Please describe:
_____
_____
Do you have any swelling? __ Yes ____ No __ Sometimes

Do you have any changes in veins? __ Yes __ No
If so, where:_____

Have you been pregnant before?__ Yes __ No # of times___
Type of births you have had in the past:
cesarean/vaginal/hospital/home/birthing center

Where are you planning to give birth? Circle all that apply
Home birth Birthing Home Hospital
_____

Will you be attempting a V-BAC(vaginal birth after cesarean)
_____

Tell me what you would like to address in the session today and list areas of concern: