Pregnancy Questionnaire

CONFIDENTIAL PATIENT INFORMATION

First Name_____ Last Name_____

Due Date _____/_____/_____ Number of weeks currently pregnant_____ Baby's Gender: Boy / Girl / Surprise

REASON/S FOR VISIT (Circle all that Apply)

☐ Wellness Visit ☐ Low Back Pain ☐ Pubic Symphysis Pain ☐ Pelvic/Hip Pain ☐ Headache ☐ Neck Pain

Other: _____

PREVIOUS PREGNANCIES

How Many? _____ Vaginal _____ C-Section _____ Miscarriage/Chemical _____

Tell us about any complications you have experienced in previous pregnancies below:

_____

_____

_____

THIS PREGNANCY (Circle all that you've experienced)

Morning Sickness Pre-Eclampsia Infertility Drugs/IVF Donor Sperm Flu-Shot - Date: _____/_____/_____

Any fertility issues? No / Yes - please explain: _____

Do you smoke? No / Yes - how many per week? _____

Do you drink alcohol? No / Yes - how many per week? _____

Do you exercise? No / Yes - please explain: _____

Do you eat a balanced diet? No / Yes - please explain: _____

Have you been ill? No / Yes - please explain: _____

Any ultrasounds? No / Yes - please explain: _____

Supplements/Vitamins (List them below):

_____

_____

Please explain any notable episodes of mental/physical stress or complications during this pregnancy:

_____

_____

_____

What are your expectations for this birth?

☐ Natural Birth ☐ Epidural Only if Necessary ☐ Definite Epidural ☐ VBAC ☐ Planned Cesarian ☐ Unsure

Other: _____

What is your biggest concern/s going into this birth?

_____

_____

_____

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Where do you plan to give birth? (Circle which applies)

Home Birth Center - Which One? _____

I'm Not Sure Yet Hospital - Which One? _____

Your Birth Team: (Circle all that apply)

☐OB ☐Midwife/s ☐Unassisted ☐Doula ☐Lactation Consultant Other: _____

Name of OB or Midwife/s: _____

OB/Midwife's Practice Name: _____ Phone: _____

May we have permission to contact your birth provider/attendant to confer with them and share information regarding the Chiropractic Care you are receiving here? Yes / No

I WOULD LIKE TO LEARN MORE ABOUT THE FOLLOWING TOPICS (Circle all that apply):

☐Doulas ☐Creating a Birth Plan ☐Chiropractic Care for Infants ☐Breast Feeding ☐Home Birth ☐Birth Center Birth

☐Birthing Classes ☐Vaccination Decision ☐Circumcision Decision ☐Delayed Cord Clamping ☐Placenta Benefits

Other: _____

I hereby authorize the doctor to examine and treat me as he/she deems appropriate through the use of chiropractic health care and I give authority for these procedures to be performed. By signing below, I am acknowledging that I have read and understand the foregoing.

Printed Name _____ Date_____

Signature _____