

Chiropractic care throughout pregnancy is essential to ensure a safer, easier birth process for mom and baby. More and more birth practitioners are recommending that their mothers receive chiropractic care throughout pregnancy. Your health is in great hands

Pregnancy Health History

GENERAL INFORMATION:

Today's Date: _____

Full Name: _____ Age: _____ DOB: _____

Home#: (____) _____ Cell #: (____) _____ Work#: (____) _____

E-mail Address: _____

Home Address: _____ City: _____ State: ____ Zip: _____

Employer: _____ Position/Duties _____

Marital Status: S M D W Name of Spouse: _____

Names and Ages of Children: _____

Do you have any x-rays prior to being Pregnant? If so where _____

Have you ever received chiropractic care? Yes No With whom? _____

Emergency Contact: _____ Phone #: (____) _____

Whom may we thank for referring you? _____

Prenatal history:

Is this your first pregnancy? Yes No If No, how many? _____

How many live births have you had? _____

How many weeks pregnant are you now? _____

Have you experienced any traumas during this pregnancy? Yes No

If Yes please comment: _____

Have you taken medications during this pregnancy? Yes No

If yes, please describe: _____

Do you smoke or drink alcohol? Yes No If yes, describe _____

Have you had any evaluation procedures (ultrasound, amniocentesis, chorionic villus sampling)? Yes No If yes, please list dates, frequency and reasons:

How has your diet been during this pregnancy? _____

Have there been any stressful events in your life during this pregnancy? Yes No
If yes, please comment: _____

What, if any, are your most significant concerns associated with this pregnancy/birth?

Who is your birth care provider? _____

Will you have someone with you at birth for support (other than birth care provider)?
Yes No Comment: _____

Where do you plan on delivering? Home or Hospital. Which hospital? _____

Have you put together a birth plan? Yes No

Previous Birth History (if applicable):

Place of birth: _____ Home _____ Birthing center _____ Hospital
Delivering Practitioner: _____ Lay Midwife _____ Nurse Midwife _____ OB/Gyn
Position of Delivery: _____ Squatting _____ Lithotomy position (on back with feet up)
_____ On Your Side _____ Kneeling _____ Other _____

Was labor induced? Yes No Unknown
Did your care provider rupture your membranes? Yes No Unknown
Did you receive any pain medications or anesthesia? Yes No Unknown
If yes, please specify type used _____

Did you receive an epidural? Yes No If yes, how many _____
Did you experience back pain during labor? Yes No Unknown

Did you deliver vaginally? Yes No
Baby presentation at time of delivery: __ Normal __ Posterior __ Brow __ Facial __ Breech
If breech, specify type: _____ Footling _____ Frank _____ Complete _____ Kneeling

Did your care provider assist delivery with his/her hands? Yes No Unknown
Was there any turning of the neck, or traction applied to the neck? Yes No Unknown

Were operative devices used to facilitate the birth? Yes No Unknown
If yes, which type? _____ Forceps _____ Vacuum Extraction

Was there any visible injury to your baby? Yes No Unknown
If so, where on your baby was the injury sustained? _____

Was there a birthing coach present? _____ Husband _____ Doula _____ Friend Other _____
At what week of pregnancy was your baby born? _____

Present State of Health (Presenting Symptoms). Most pregnant women visit our office to give themselves and their baby the best opportunity to have a healthy birth process. However, some women also experience symptoms during their pregnancy. If you have a specific concern please complete the following section as this vital information will help Dr. Joe understand your current concern and subluxation pattern. A subluxation occurs when your spine does not move properly, placing dangerous pressure on your spinal nerves which connect your brain to your body.

1) **WHEN & HOW** did your current complaint begin? _____

2) Please circle one: Is your concern **new (acute)** or **old (chronic)**?

3) What time of day is your complaint better? _____

4) What time of day is your complaint worse? _____

5) What makes your complaint better? _____

6) What makes your complaint worse? _____

7) Does your complaint worsen if you cough/sneeze/push to move your bowels? _____

8) What other healthcare professionals have you consulted for your complaint? _____

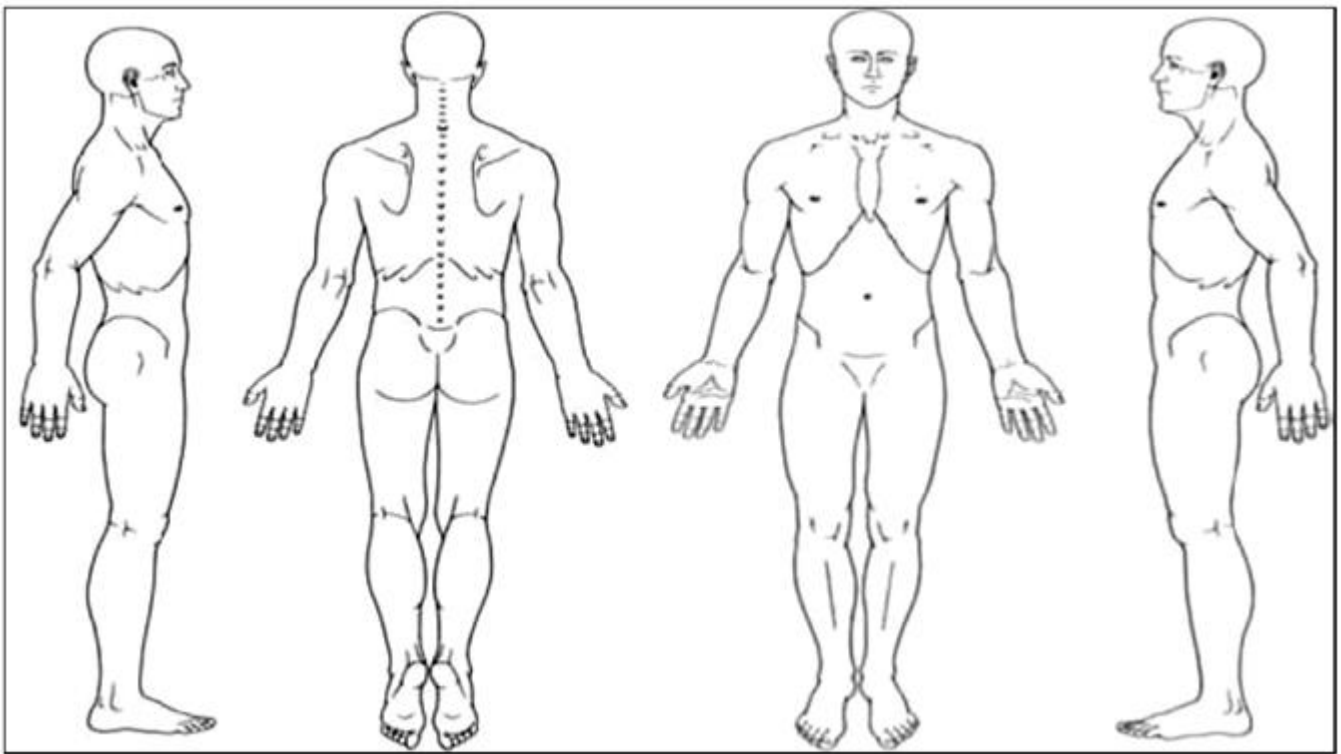
What care was provided? _____

9) Please circle any and all symptoms that best fit your current concern:

Sharp Dull Ache Numb Shooting Burning Tingling Crampy

10) Please mark where you feel your concerns on the diagram below.

11) Rate your current level of symptoms on a 0-10 scale. (0 = none, 10 = worst) Symptom Level _____



12) Please circle one: If you are having symptoms, how often do you experience your symptoms?

All of the time: (76-100% of the day)

Most of the time: (51-75% of the day)

Some of the time: (26-50% of the day)

A little bit: (up to 25% of the day)

13) How are your concerns changing? Getting Better Not Changing Getting Worse

14) How much have your concerns interfered with your lifestyle? (Please circle one)

Not at all

A little bit

Some of the time

Most of the time

All of the time

15) How would you rate your current overall health: Poor Fair Good Very Good Excellent

The information I have written is accurate and true. Sign _____ Date _____

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