



## PREGNANCY QUESTIONNAIRE

Last Name \_\_\_\_\_ First \_\_\_\_\_ Today's Date \_\_\_\_\_  
Date of last normal menstrual cycle \_\_\_\_\_ Due Date \_\_\_\_\_ Number of weeks pregnant \_\_\_\_\_  
Names and ages of other children \_\_\_\_\_  
Previous chiropractic care \_\_\_\_\_

## PRENATAL HISTORY

Is this your first pregnancy? \_\_\_\_\_

How many other times have you given birth? \_\_\_\_\_

Have you experienced any traumas during this pregnancy? (accidents, falls)  Yes  No If yes, please describe \_\_\_\_\_

Any medications taken during this pregnancy? Please list: \_\_\_\_\_

Have you had any evaluation procedures?  Ultrasound  Amniocentesis  Chorionic villus sampling List dates, frequency and reason for these procedures: \_\_\_\_\_

How has your diet been during this pregnancy? \_\_\_\_\_

Have there been any stressful events in your life during this pregnancy? \_\_\_\_\_

Do you have any significant fears associated with this birth? \_\_\_\_\_

Will you have someone with you at birth for support (other than care provider)?  Yes  No If yes, who? \_\_\_\_\_

Have you put together a birth plan? \_\_\_\_\_

Is there anything we should know about you or this pregnancy? \_\_\_\_\_

What birthing classes have you decided to take? \_\_\_\_\_

Where do you plan to give birth? \_\_\_\_\_ Do you plan to use an  Obstetrician  Midwife

### I would like to receive more information on:

- Birth attendants  Birth plans  Circumcision  Infant care  Vaccinations  
 Birthing classes  Breast feeding  Home birth  Ultrasound

## BIRTH CARE PROVIDER

Name of Obstetrician or Midwife \_\_\_\_\_

Practice Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

May we have your permission to contact your birth provider to share information regarding the chiropractic care that you are receiving here?  Yes  No