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 recieve 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