Pregnancy Questionnaire

Patient Name: _____ Date: _____

BIRTH HISTORY & PLAN

What is your calculated due date? _____

Who is your OB/GYN or midwife? _____

Where will you give birth? _____

Do you wish to have a natural vaginal labor and delivery? ☐ Yes ☐ No

Is this your first pregnancy? ☐ Yes ☐ No

If not, please tell us about your previous pregnancy and/or birth experience(s):

_____

_____

CURRENT PREGNANCY CONDITIONS

Are you currently experiencing any aches or pains? ☐ Yes ☐ No

If yes, please explain: _____

Please tell us about your current diet, and any dietary restrictions:

_____

Have you had any slips, falls, or other physical traumas during the pregnancy? ☐ Yes ☐ No

If yes, please explain: _____

Have you had any major emotional stressors during your pregnancy? ☐ Yes ☐ No

If yes, please explain: _____

Did/do you experience morning sickness? ☑ Yes ☐ No

If yes, please explain: _____

Is there anything else you would like us to know about your pregnancy or birth plan?

_____

YOUR POST BIRTH PLAN

Do you plan to breastfeed your child? ☑ Yes ☐ No

What are your plans for vaccines? ☑ Full Schedule ☐ Delayed Schedule ☐ None

We offer a complimentary newborn check for baby if mom was seen at our office during pregnancy! Would you like more information about chiropractic for children? ☐ Yes ☐ No

ACKNOWLEDGEMENT & CONSENT

I certify that I understand that providing a full health history is imperative for the doctor(s) to make the best plan and choices for care. I affirm that I have thoroughly and honestly completed these intake forms to the best of my ability. I acknowledge that a comprehensive evaluation is necessary to determine the next steps most appropriate in this case.

Patient Signature: _____ Date: _____