Pregnancy Questionnaire

Patient Name: _____ Date: ___/___/_____

Due Date: ___/___/____

PREVIOUS BIRTH EXPERIENCE

Is this your first pregnancy? Yes No

-If not, please tell us about your previous pregnancy and/or birth experience(s) i.e: c-section, vaginal, home birth etc.

_____

_____

_____

Do you plan to follow the same plan as your previous delivery? Yes No

-If no, what would you like to change? _____

_____

CURRENT HEALTH CONDITIONS

What type of exercise(s) are you currently performing? _____

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

Have you taken any medications or supplements during your pregnancy? Yes No

-If yes, please explain: _____

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: _____

YOUR BIRTH PLAN

Your top three goals for this pregnancy:

1. _____
2. _____
3. _____

Your top three postpartum goals:

1. _____
2. _____
3. _____

Who is your OB/GYN or midwife? _____

In regards to your pregnancy, labor and Delivery- What is your biggest fear(s)? _____

_____

What would you like to gain from chiropractic care during your pregnancy? (Please Circle ALL that apply)

Comfort Sleep Improvement Prepare my body for Delivery Help with recovering from birth (postpartum) Other_____

I would like to receive resources/information on:

Natural birth Out of hospital birth Doulas Midwives Vaccinations
Essential Oils Birth Classes Birth Plans Breastfeeding Support Acupuncture/Massage