

# Post Natal Health Questionnaire

**Congratulations on your new bundle of joy!**

Your Name: \_\_\_\_\_

**Please help us help you today by providing the following information:**

Baby's Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Gender: \_\_\_\_\_

**Please check all that apply:**

- |   |   |
|---|---|
| <input type="checkbox"/> Born on due date                     | <input type="checkbox"/> Forceps Used                               |
| <input type="checkbox"/> Born premature      How early? _____ | <input type="checkbox"/> Vacuum extraction used                     |
| <input type="checkbox"/> Born past due      How late? _____   | <input type="checkbox"/> Umbilical cord was around baby's neck      |
| <input type="checkbox"/> Went into labor naturally            | <input type="checkbox"/> Approximately how long did you push? _____ |
| <input type="checkbox"/> Medically induced labor              | <input type="checkbox"/> Nursing currently                          |
| <input type="checkbox"/> Water broke naturally                | <input type="checkbox"/> Pumping currently                          |
| <input type="checkbox"/> Water broken by doctor               | <input type="checkbox"/> Formula only currently                     |
| <input type="checkbox"/> Vaginal Birth                        | <input type="checkbox"/> Both breast milk and formula               |
| <input type="checkbox"/> VBAC                                 | <input type="checkbox"/> Baby up to date on vaccines                |
| <input type="checkbox"/> Scheduled cesarean                   | <input type="checkbox"/> Modified / delayed vaccine schedule        |
| <input type="checkbox"/> Emergency cesarean - Reason: _____   | <input type="checkbox"/> Religious vaccine exemption                |
| <input type="checkbox"/> Epidural used                        | <input type="checkbox"/> Medical vaccine exemption                  |

Any issues with baby's health? \_\_\_\_\_

\_\_\_\_\_

How are you feeling physically? \_\_\_\_\_

\_\_\_\_\_

How are you feeling mentally? \_\_\_\_\_

\_\_\_\_\_

**Interested in more information on any of the following?:**

- |   |  |
|---|--|
| <input type="checkbox"/> Chiropractic care for infants & toddlers | <input type="checkbox"/> Meal planning                 |
| <input type="checkbox"/> Baby wearing                             | <input type="checkbox"/> Postpartum emotional wellness |
| <input type="checkbox"/> Cloth diapers                            | <input type="checkbox"/> Pelvic floor physical therapy |
| <input type="checkbox"/> Lactation consultant                     | <input type="checkbox"/> Postpartum doula              |

Signature: \_\_\_\_\_ Today's Date: \_\_\_\_\_