PREGNANCY QUESTIONAIRE

Personal Information

Name: ____ Date: _____________
DOB: ________________ Age: _____________ Sex: □ M □ F Marital Status: □ S □ M □ D □ W
Address: ____
Email: ____ Home
Phone: (   )____________ Cell: (   ) ____________________ ***Work:*** *(*   )______________
Occupation: __________________ Employer: __________________
Spouse's Name: __________________ Spouse's Employer: __________________
Insurance Company: __________________ Insured Name: __________________
Policy Number: __________________ ID#: __________________
Who may we thank for referring you to our office? _________________

CURRENT PREGNANCY

Due Date/Week: _____________________ I am in my ______________week of pregnancy
Pre-pregnancy Weight: ______________________ Current weight: _____________
Height: ______________
Childbirth preparation:

- Bradley Method: _______________________
- La Maze: ________________________

Midwifery:
____
Childbirth caregivers:

- OB/GYN: _______________________
- Midwife: _______________________
- Doula: ________________________

Caregiver's Name and Phone Number:
____
Pre-pregnancy BP? __________________Current blood pressure: ______________________
I plan on giving birth at a (select one): □ Hospital □ Home □ Birthing Center
Name of Hospital or Birthing Center:
____
What position do you sleep in? □ Side □ Back □ Stomach

Any traumas during this pregnancy? □ Yes □ No If yes, please explain:
____

Any hospitalizations during this pregnancy? □ Yes □ No If yes, please explain:
____

Any medications taken during this pregnancy, including over the counter medications and supplements?

Any fertility treatments? □ Yes □ No If yes, please explain:
____

Lifestyle Questions

Smoker? □ Yes □ No If yes, how many packs per day? ___________________
Drink coffee? □ Yes □ No If yes, how many cups per day? ________________
Drink soda? □ Yes □ No If yes: □ Regular □ Diet: How many per day? __________
Drink tea? □ Yes □ No If yes, how many cups per day? __________
How many ounces of water per day? ________
What are you doing for exercise?
____
Are you eating a balanced diet? ____________________
Are you sleeping at least 8 hours a day? ______________
Are you planning on breastfeeding post-delivery?
____
Are you currently working? _________________________
Do you sit the majority of the day? ___________________
Have you had any pregnancy evaluation procedures performed? (i.e. ultrasound, amniocentesis, chronic villus sampling, etc.) If yes, please explain:
____

Reason for Seeking Care

(check all that apply)
□ Breech presentation/Malposition □ Backache □ Trauma □ Headache □Wellness
□ Increase chance of healthy labor and delivery □ Pain relief □ Healthier immune system
□ Other: ____
What are your most significant fears associated with this pregnancy or birth process?

Previous Pregnancies

Number of previous pregnancies: _____________________
Number of previous births: __________________________
Names and ages of children:
____
At what weeks were your children born?
____
Where did your previous births take place?
____

Please list medications or any anesthesia used during previous births:
____
Please check interventions used in previous births:
□ Breaking of water □ Vacuum extraction □ Episiotomy □ Cesarean section
□ Membranes stripped □ Forceps
How long was your previous labor? Total: ___________________
Time before you pushed: ________________________________
Did you have chiropractic care during your previous pregnancies?
____
Describe your stress level on a scale of 1-10 (1=none/10=extreme)
Occupational: _______________________Personal: _______________________________
Current position of your baby: □ Head down □ Posterior □ Transverse □ Breech □ Not sure

Previous Health History

Please check all symptoms you have ever had, even if they do not seem related to your current problem:
□ Headaches □ Pins and needles in extremities □ Loss of balance □ Dizziness □ Fainting
□ Sinus conditions □ Back pain □ Numbness in extremities □ Irritability □ Ringing in ears
□ Nervousness □ Depression □ Neck Pain □ Upset stomach □ Loss of taste
□ Cold sweats □ Fatigue □ Sleeping problems □ Reproductive Disorders
□ Menstrual pain □ Ulcers □ Constipation □ Concussion □ Hot flashes □ Fainting
□ Heartburn □ Mood swings □ Thyroid issues □ Stiff neck

What is your biggest fear as you approach birth?
____
If you are experiencing current, or ongoing stress please explain:
____
Do you practice stress management techniques? If so, please explain:
____

GOALS FOR YOUR CARE

People seek chiropractic care for a variety of reasons. Some go for relief of pain; some go to correct the cause of pain and others go for correction of whatever is malfunctioning in their body. Your doctor will weigh your needs and desires when recommending your care program. Please check the type of care desired so that we may be guided by your wishes whenever possible. PLEASE PICK ONE.

□ Relief Care: Symptomatic relief of pain or discomfort
□ Corrective Care: Correcting and relieving the cause of the problem as well as the symptom or pain
□ Comprehensive Care: Get out of pain, correct the underlying cause, and function at an optimal level
□ I want the Doctor to select the type of care for my condition
If there are any issues that you are experiencing, or that you have concerns about that have not been addressed yet, please write them below:

CONSENT for examination and care: Please Read Carefully

In order for my health professional as indicated below to make a determination on the suitability of my case for care, I acknowledge and understand that I must complete a thorough evaluation. I do hereby request and consent to the performance of such an evaluation by the person(s) named below, or any party authorized to do so by that person.

I have had the opportunity to discuss with the Doctor of Chiropractic indicated below, or with any party authorized to do so by that Chiropractor, about the nature and purpose of the examination process. I understand that there may be remotely associated risks with examinations, as there are with any and all healthcare treatments. In healthcare, the matter of whether any treatment is appropriate or not is determined by looking at the level of risk and comparing this with the level of expected benefit. I understand that I may ask the doctor to stop the examination at any time. I also understand that by signing this form, the chiropractor continues to be obligated for best practices delivered in my interests.

Name: ____ Date: _________________
Signature: _____________________________ Witness: ____________________________

Doctor of Chiropractic: Leslie M Bryan, DC & Timika Frazier, DC
Address: 11322 US Highway 31 Spanish Fort, AL 36527