Pregnancy Health History

Patient Name _____ Date _____

Early Pregnancy

When was your last menstrual cycle?

When is your calculated due date ("Guess date")?

Did you have any difficulty conceiving? ◯ Yes ◯ No
If yes, please explain:

Have you experienced any morning sickness? ◯ Yes ◯ No
If yes, please explain:

Current State of Health

How often are you exercising?
What types of exercise(s) do you enjoy?

Please describe your eating habits and any dietary restrictions:

Have you taken any supplements or medications during your pregnancy? ◯ Y ◯ N
If yes, please explain:

How would you rate the level of emotional stress during your pregnancy? / 10 (10 being the highest)
Which of the following contribute to your emotional stress? ◯ Work ◯ Home ◯ Finances ◯ Health
What activities help you relieve your stress?

Have you had any slips, falls, or other physical stress during your pregnancy? ◯ Y ◯ N
If yes, please describe:

Previous Pregnancy

Is this your first pregnancy? ◯ Y ◯ N
If no, please describe any previous pregnancies and birth experiences:

What worked well in your previous pregnancy and delivery?

What would you like to do differently for this pregnancy and delivery?

Current Birth Plan

Do you currently have a birth plan? ○ Y ○ N
If yes, please describe your wishes:

Will you take any prenatal or birth classes? ○ Y ○ N
If yes, which one(s)?

Where will you be delivering your baby?
Who is your OB/GYN or midwife?
Do you have a birth coach or doula? ○ Y ○ N

What are your top 3 goals for this pregnancy?
1.
2.
3.

What would you like to gain from chiropractic care during your pregnancy?

What are you wondering?

Post Birth

Do you plan to breastfeed your baby? ○ Y ○ N

Do you plan to vaccinate your baby? ○ Y ○ N
Do you have questions regarding vaccines? ○ Y ○ N
-If yes, please explain:

Would you like a complimentary nervous system evaluation for your baby following delivery?
○ Y ○ N

Name _____ Date _____ / _____ / _____