ADJUST
CHIROPRACTIC HEALTH CENTER

PREGNANCY

Questionnaire

PRACTICE MEMBER NAME: _____ DATE: _____

PREVIOUS BIRTH EXPERIENCE

Is this your first Pregnancy? ☐ Yes ☐ No **If no**, how many pregnancies previously? _____

How many children do you have? _____ What are their names? _____

How many vaginal deliveries? _____ How many cesarean deliveries? _____

Was labor induced using Pitocin? ☐ Yes ☐ No ☐ N/A ☐ I don't know

Was there any hip or back pain during labor? ☐ Yes ☐ No

Was baby in a suboptimal or abnormal position during the pushing phase of labor? ☐ Yes ☐ No ☐ N/A ☐ I don't know

Did you receive an epidural? ☐ Yes ☐ No

Were there any operative devices used? ☐ Yes ☐ No ☐ Forceps ☐ Vacuum

Any postpartum complications or long-term consequences? ☐ Yes ☐ No

Any other details you would like to provide? _____

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

If not, what would you like to change? _____

CONCEPTION & EARLY PREGNANCY

When is your expected or calculated due date? _____ How many weeks are you? _____

Did you have any difficulty conceiving? ☐ Yes ☐ No

If yes, please explain: _____

Have you used any form of hormonal contraceptives? ☐ Yes ☐ No

If yes, which ones and how long? _____

Have you experienced morning sickness? ☐ Yes ☐ No

If yes, please explain: _____

LIFESTYLE HABITS

Are you currently exercising? ☐ Yes ☐ No

If yes, please describe: _____

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

If yes, please explain: _____

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Are you following a diet/meal plan or have any dietary restrictions? ☐ Yes ☐ No

If yes, please explain: _____

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

If yes, please explain: _____

YOUR BIRTH PLAN

What are your top 3 goals for this pregnancy?

1. _____
2. _____
3. _____

Do you currently have a birth plan? ☐ Yes ☐ No

If yes, please attach a copy or explain: _____

_____

_____

Are you taking any pre- natal or birthing classes? ☐ Yes ☐ No

If yes, please explain: _____

_____

Do you have an OBGYN? ☐ Yes ☐ No If yes, who? _____

Do you have a midwife? ☐ Yes ☐ No If yes, who? _____

Do you have a doula? ☐ Yes ☐ No If yes, who? _____

Do you wish to have a medicine free labor and delivery? ☐ Yes ☐ No

What pregnancy resources can we help connect you with? _____

_____

Do you plan on breastfeeding your child? ☐ Yes ☐ No

Is there anything else you'd like to tell us about your pregnancy or birth plan, or are there any concerns you have? ☐ Yes ☐ No

If yes, please explain: _____

SIGNATURES

_____ _____

Patient Signature **Date Form Completed**

_____ _____

Doctor Signature **Date Form Reviewed**