

Today's Date (DD/MM/YY): PATIENT NAME:
PREVIOUS BIRTH EXPERIENCE
Is this your first pregnancy? \Box Yes, \Box No
If No, please tell us about your previous pregnancy and/or birth experience(s):
Do you plan to follow the same plan as your previous delivery? \Box Yes, \Box No
If no, what would you like to change?
CONCEPTION AND EARLY PREGNANCY
When is your expected or calculated due date?
Did you have any difficulty conceiving? \Box Yes, \Box No
If yes, please explain:
Have you ever used any form of hormonal or oral contraceptives? \Box Yes, \Box No
If yes, which ones, and for how long?
When was your last menstrual cycle?
What was your pre-pregnancy weight? lbs Current weight? lbs
Have you experienced morning sickness? \Box Yes, \Box No
If yes, please explain:
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? \Box Yes, \Box No
If yes, please explain:
Have you had any major emotional stressors during your pregnancy? \Box Yes, \Box No
If yes, please explain:



YOUR BIRTH PLAN
Your top three goals for this pregnancy:
1
2
3
Do you currently have a birth plan? \Box Yes, \Box No
If yes, please explain:
Are you taking any pre-natal or birthing classes? \Box Yes, \Box No
If yes, please explain:
Who is your OB/GYN/midwife?Will they be present for delivery? \Box Yes, \Box No
Do you wish to have a natural vaginal labour and delivery? \Box Yes, \Box No
If no, what concerns do you have?

YOUR POST-BIRTH PLAN
Do you plan on breastfeeding your child? \Box Yes, \Box No
Is there anything else you'd like to tell us about your pregnancy or birth plan?
What would you like to gain from chiropractic care during your pregnancy?
Are there any burning questions you want to be sure to ask today?