Pregnancy Health History Form

Name: ___________________________________
Date:__________________________
Age: ______ Birth date: mm/dd/yyyy _____________
E mail address: _________________________________
Address:____
Phone: ________________ Marital Status: _____________
Occupation: _____________________ Who may we thank for referring you?___________
Family doctors name and address: ____

WHY THIS FORM IS IMPORTANT Our focus is on assisting clients to function optimally, for them to become more self aware, stronger, healthier and for improved adaptation to everyday stresses. Completion of this form provides us with an improved understanding of your physical, emotional and chemical stresses that can gradually overwhelm the body over time and contribute to health problems. Please complete this form as thoroughly as possible and the doctor will review it with you. Information on this form is strictly confidential and will not be shared without your consent.

#1 Current Health Concern (if there are no current concerns and this assessment is to ensure optimum health, function and wellness tick this box) ☐
Health Concern:____
____
If pain is involved, rank it on a scale of 1 to 10 (1 is minimal, 10 is extreme) __________
Circle or describe it's character (sharp, dull, ache, burning, tingling, throbbing, spasms)
____________________________ When did you notice it?________________
What happened? ____________________ How often does it occur?______________
What relieves?____________________ What aggravates?_____________________
Does it radiate or cause problems somewhere else? __________________________
Any associated or related concerns? ______________________________________
Other professionals seen for this ____
Treatment and results____

 # 2 About Your Pregnancy: (circle answer)
Is this your first pregnancy? **Yes / No**
If this is not your first, how many times have you been pregnant? _______
Have you had any complications with previous pregnancies? **Yes / No** (explain if yes)
____

What is the estimated date of delivery? ____________________________________
Who is your primary care giver for delivery? Obgyn / GP/ Midwife? Name: ___________

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What is your planned location for delivery? Hospital / Home/ Birthing clinic/other
How do you feel about this pregnancy? ____
Do you have a birth plan? **Yes / No**
Would you like information on creating one? **Yes / No**
Any special arrangements for the birth? (planned C-sec, water delivery, birth chair, squat, other)____
Have you had any testing? Genetic, blood, ultrasound, amniocentesis, chorionic villi sampling, other)?
Dates and reasons: ____
Are you planning on breastfeeding post delivery? **Yes / No**
Would you like further information on the advantages of breastfeeding? **Yes / No**
Was you blood pressure prior to pregnancy within normal range, low or high? _________
What is your present blood pressure and when was it last checked? ________________
Have you changed your diet/menu since learning of your pregnancy? **Yes / No**
Have you smoked prior to or along with this pregnancy? **Yes / No / Quit** ____________
Have you had alcohol during this pregnancy? **Yes / No** ____________________________

Have you noticed:
Swelling in the arms or legs? (circle) **Yes / /No**
Low back pain? **Yes / No** How often? ____
Upper back pain? **Yes / No** How often? _______________________________________
Neck pain? **Yes / No** How often? ____
Rib or chest pain? **Yes / No** How often? _______________________________________
Any foot pain? **Yes / No** How often? ____
Digestive complaints? Heartburn, constipation? **Yes/ No** __________________________
Nausea or vomiting? **Yes / No** Frequency and when? ____________________________
Arm or hand numbness/tingling? **Yes / No** How often? ___________________________
Dizziness or lightheadedness? **Yes / No** How often? _____________________________
Headaches? **Yes / No** How often?
Pain radiating down the leg(s)? **Yes / No** How often? ____________________________
Heart palpitations? **Yes / No** How often? _______________________________________

If pain from anything noted above is involved, rank it on a scale of 1 to 10 (1 is minimal, 10 is extreme) ______________
Circle or describe it's character (sharp, dull, ache, burning, tingling, throbbing, spasms, other) ________________________________
When did you notice it?_________________
What happened? ______________________ What relieves?______________________
What aggravates?_________________________
Does it radiate or cause problems elsewhere? ___________________________________
Any associated or related concerns? ____

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Professionals seen for this? (name) ____
Treatment and results____

Other health concerns: Please note all other health concerns present or in the past.
Diseases history: (please circle all that apply)
Allergies, Stuffy nose, Runny sinuses, Frequent colds, Loss of balance, Difficulty concentrating, Fatigue, Indigestion, Bloating, Appendicitis, Asthma, Bronchitis, Emphysema, Pneumonia, Bleeding disorders, Cancer, Cataracts, Vision changes, Diabetes, Hypoglycemia, Epilepsy, Heart Disease, Hypertension, Migraines, Hepatitis, High cholesterol, Difficulty digestion, Loose stools, Hernia, Herniated Disc, Kidney Disease, Liver disease, Multiple Sclerosis, Osteoarthritis, Rheumatoid arthritis, Osteoporosis, Parkinson's Disease, Thyroid problem, Tonsillitis, Ulcers, Urinary tract infections, Ulcerative colitis Other (list):
____

#3 Physical stresses

Any significant injuries, falls or traumas during infancy or childhood? **Yes No Unsure**
(if yes please explain) ____
Any significant injuries, falls or traumas (car accidents) during adulthood? **Yes No Unsure**
(if yes please explain) ____
Any hospital visits? **Yes No**
Explain____ Have you had any surgeries, fractures? **Yes No** Explain and dates ____
Are you in prolonged postures (ex: repetitive work, lifting, sitting, driving) **Yes No Unsure**
(if yes, please explain)____
Any hobbies that are physically strenuous or have repetitive movements? **Yes No Unsure**
(if yes, please explain)____
What is your usual exercise routine? ____
Any fractured bones or dislocations? ____
Any vehicle accidents? **Yes No** What happened and when? __________________________

#4 Chemical Stresses

Are you taking prescription or over-the-counter medications? **Yes / No (**If yes, please indicate what you are taking and why)
____
Are you currently taking supplements? **Yes / No**(if yes, which ones and why?) ____________
____
Do you drink tap water? **Yes / No / Occasionally**
Are you exposed to pollutants, strong smells, chemicals, aerosols? **Yes No Occasionally**
Do you eat organic? **Yes / No / Occasionally**
Do you use natural or environmentally friendly products in your home? I.E. Cleaning supplies, hair and makeup, etc. **Yes / No** ____

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#5 Mental/Emotional Stresses

Since psychological stress has been shown to affect numerous systems and fetal function, please let us know how you are coping with life's stresses. Rank from 1 to 10 with 1 being minimal to 10 being extreme)

Life in general I feel ______ Work and Career I feel _____ Relationships I feel ______
Financial stress I feel _____ Time management I feel ____ Sports & hobbies I feel ___
Health and well-being I feel ____ Quality of sleep I feel ____ About my pregnancy I feel _
If you are experiencing significant or ongoing stress please explain ____________________
____

Do you practice some form of meditation, breath work, other mind-body movement or have a routine to reduce your stress? **Yes /No** Explain __________________________________

#6 Family Health History

Please note any health issues that are present with family members such as parents, siblings, significant other or children. Cancer, hypertension, stroke, arthritis, kidney disease, dementia, diabetes, other____

#7 Why are you here?

People seek chiropractic care for a number of reasons and have certain expectations and perceptions. Please tick the goals which apply to you so we can accommodate your wishes.

Improvement in function ___ Pain reduction ___ Relief ___ Improved quality of life ____
Manage my crisis___ Information on prevention ___Symptom management ____
Healthier immune system ___ Stress reduction ___ Keep me moving___ Optimum function and quality of life ___ Improved performance ____ Full body integration____ Wellness ____
Longevity _____________ Other____

Thank you for completing this form. If you have anything to add on the back of this form, please add notes which can then be discussed with the doctor. If there are any other questions or concerns which you have, please discuss with the doctor.