Pregnancy Questionnaire

**Please fill out as thoroughly as possible as this will help us to serve you optimally!

PREVIOUS BIRTH EXPERIENCE

Is this your first pregnancy? Yes No

- If not, please tell us about your previous pregnancy and/or birth experience(s)

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

- If no, what would you like to change?

CONCEPTION & EARLY PREGNANCY

When is your expected or calculated due date?

Did you have any difficulty conceiving? Yes No

- If yes, please explain:

Have you ever used any form of hormonal or oral contraceptives? Yes 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? Yes 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? Yes no

- If yes, please explain:

Have you had any major emotional stressors during your pregnancy? Yes 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? Yes No

- If yes, please explain:

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

- If yes, please explain:

Who is your OB/GYN or midwife? Will they be present for delivery? Yes no

Who is your birth provider?

Do you intend to have a doula or birth coach present? Yes no

- If yes, please explain:

Do you wish to have a natural vaginal labor and delivery? Yes no

- If not, what concerns do you have?

YOUR POST-BIRTH PLAN

Do you plan on breastfeeding your child? Yes No

Any concerns regarding breastfeeding?

What do you intend to do for vaccines?

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?

Patient Name: ______________________________ Date: _______ / _______ / _________