Natural Living
CHIROPRACTIC & ACUPUNCTURE

Additional Health Information for Pregnant Patients

Problems/complaints during pregnancy? _____

Name of OB/Midwife/Family MD:_____

Have you been under medical care for this pregnancy? For what condition and how long? _____

_____

Medications and/or supplements? How long have you been taking them?_____

_____

List all accidents/injuries?_____

Ultrasound? N / Y Dates, reasons, & conclusions _____

_____

Baby's position at last check up: (circle) head down feet down transverse

Number of previous pregnancies? _____ Complications with pregnancies? _____

Number of successful deliveries? _____ Problems/complaints with deliveries? _____

_____

Current stress level? (circle) none low medium high unbearable

Primary cause of stress? _____

Planned birth location? (circle) Home Birth Center Hospital

Phone number and address of location: _____

Do you plan to breastfeed? Y / N

Sleeping posture: (circle) Side Back Stomach

Difficulty eating or keeping food down? Y / N

Special diet or food restrictions? _____

Do you track your protein intake? Y / N

List your favorite foods that you frequently eat: _____

_____

How much do you consume of the following (please note amount/servings per day/week):

- Carbonated drink _____
- Caffeine _____
- Water _____
- Sweets _____
- Vegetables _____
- Protein _____

Do you exercise? Y / N If so, what exercises, how much, how often? _____

_____

Are you taking/do you plan to take any birthing classes? N / Y - Name of class? _____

_____ _____

Patient Name Age

_____ _____

Patient or Parent/Guardian (if minor) Signature Date