Jackson Chiropractic Clinic

PREGNANCY HEALTH HISTORY

Identification Information

Full Name _____ Nickname _____
Last First MI

Pregnancy History

Due date: _____ # of weeks pregnant: _____

Reason for today's visit: ☐ Wellness Visit ☐ Low Back Pain ☐ Pubic Symphysis Discomfort

☐ Pelvic/Hip Discomfort ☐ Headache/Neck Pain ☐ Other: _____

How many children do you have? _____ How many pregnancies have you had?_____

If you have children, how were they delivered? ☐ Vaginal ☐ C-section

Where do you plan to give birth? ☐ Home ☐ Birth Center, _____ ☐ Hospital, _____

Name of Obstetrician/Midwife: _____ Are you using a doula? ☐ Yes ☐ No

If **yes**, name of doula: _____

What are your hopes or expectations for the birth? (check all that apply)

☐ Natural birth ☐ Epidural, only if necessary ☐ Definite epidural ☐ VBAC

☐ Planned C-section ☐ Unsure ☐ Other: _____

What prenatal vitamin are you taking? _____

During your pregnancy, do/did you use any of the following:

	Yes	No	Explanation
Tobacco?	☐	☐	_____
Alcohol?	☐	☐	_____
Non-prescribed drugs?	☐	☐	_____
Prescription medications?	☐	☐	_____
Over the counter meds?	☐	☐	_____
Vaccinations?	☐	☐	_____

During your pregnancy, do/did you have any of the following:

	Yes	No	Explanation
Falls?	☐	☐	_____
Motor vehicle accident or near-miss?	☐	☐	_____
High blood pressure?	☐	☐	_____
Diabetes?	☐	☐	_____
Anemia?	☐	☐	_____
Morning sickness?	☐	☐	_____
Swollen ankles?	☐	☐	_____
Back pain?	☐	☐	_____
Muscle or ligamentous pain?	☐	☐	_____
Abnormal bleeding?	☐	☐	_____
Any other injuries or illnesses?	☐	☐	_____

Anything else we should know about your pregnancy?

_____

_____

_____

Patient Signature _____ Date _____