Naturally Aligned Family Chiropractic, P.A.

Pregnancy Health History Form

Patient Name ______________________ Age ______ Birth Date ____/____/______

Address ______________________ City ______________________ Zip __________

Home phone ______________________ Cell ______________________ Work phone ______________________

Email ______________________ Single/Married/Divorced (circle one)

Occupation ______________________ Employed by: ______________________

Partner's Name/ Occupation______________________

No. of Children ______ ; Names/Ages ______________________

Who may we thank for referring you? ______________________

Your Health Profile

How many weeks pregnant are you today? ______________ Estimated due date? ______________________

Birth Attendants/Primary Care Providers *Name(s):*

- ◻ Medical Doctor/OB ______________________
- ◻ Midwife ______________________
- ◻ Doula ______________________

Anticipated location of delivery: ______________________

Check if you: ◻ Sit more than 4 hours per day ◻ Drive for more than 2 hours per day
◻ Construction or physical labor ◻ Do repetitive motions throughout the day

Have you ever suffered from….	Before pregnancy	During pregnancy		Before pregnancy	During pregnancy
Nausea/Morning sickness	◻	◻	Headaches	◻	◻
Back pain/ Sciatica	◻	◻	Neck/shoulder pain	◻	◻
Pubic pain/pressure	◻	◻	Heartburn	◻	◻
Diabetes	◻	◻	Restless or Crampy Legs	◻	◻
High blood pressure	◻	◻	Asthma or allergies	◻	◻

What is your **primary concern** today? ______________________

If you experience pain, is it: ◻ Sharp ◻ Dull ◻ Comes & goes ◻ Travels ◻ Constant

Since the problem started, is it: ◻ About the same ◻ Getting better ◻ Getting worse

What makes it worse? ______________________ better ______________________

Does it interfere with: ◻ Work ◻ Sleep ◻ Walking ◻ Sitting ◻ Hobbies ◻ Leisure

List any ***medications***, ***vitamins*** or ***supplements*** you are taking ______________________

____

Have you had ***surgery*** or been ***hospitalized***? (circle) If yes, please explain ______________________

____

Have you had a ***fall*** - ***accident*** - ***injury***? (circle) If yes, please explain ______________________

____

Any previous **chiropractic care?** Yes/No (circle). Last adjustment? __________ Reason for leaving? ______________

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Signature ______________________ Today's Date ______________