

# Pregnancy Health History Form

Name: \_\_\_\_\_  
Date: \_\_\_\_\_  
Age: \_\_\_\_\_ Birth date: dd/mm/yyyy \_\_\_\_\_ Sex: F Patient Number: \_\_\_\_\_  
E mail address: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone:(H) \_\_\_\_\_ (W) \_\_\_\_\_ (cell) \_\_\_\_\_ Marital Status: S M W D CL  
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)

## **# 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)

\_\_\_\_\_  
If you have had miscarriage(s), how far along in your pregnancy did it occur?

\_\_\_\_\_  
Was this pregnancy planned? **Yes / No**

What is the estimated date of delivery? \_\_\_\_\_

Who is your primary care giver for delivery? Obgyn / GP/ Midwife? Name: \_\_\_\_\_

What is your planned location for delivery? Hospital / Home/ Birthing clinic/other

How do you feel about this pregnancy? \_\_\_\_\_

Have you 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) \_\_\_\_\_

Would you like additional information on options for birth posturing? **Yes / No**

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**

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Would you like further information on the advantages of breastfeeding? **Yes / No**  
Was your 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**  
Would you like further information on healthy nutrition for 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? \_\_\_\_\_

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, Lowered resistance, 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,

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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 bottled 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 \_\_\_\_\_

Do you drink or bathe/shower in chlorinated water? Yes / No \_\_\_\_\_

## #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

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routine to reduce your stress? Yes /No Explain \_\_\_\_\_

Are you interested in learning about stress reduction practices? Yes / No

## #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

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## #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 \_\_\_\_\_

## CONSENT for examination and care once a report if findings has been reviewed: Please Read Carefully

In order for my health professional as indicated below to make a determination on the suitability of my case for care, I acknowledge and understand that I must complete a thorough evaluation. I do hereby request and consent to the performance of such an evaluation by the person(s) named below, or any party authorized to do so by that person.

I have had the opportunity to discuss with the Doctor of Chiropractic indicated below, or with any party authorized to do so by that Chiropractor, about the nature and purpose of the examination process. I understand that there may be remotely associated risks with examinations, as there are with any and all healthcare treatments. In healthcare, the matter of whether any treatment is appropriate or not is determined by looking at the level of risk and comparing this with the level of expected benefit. I understand that I may ask the doctor to stop the examination at any time. I also understand that by signing this form, the chiropractor continues to be obligated for best practices delivered in my interests.

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Witness: \_\_\_\_\_

Doctor of Chiropractic:  
Address:

F. Indra Bayne  
3300 FM 1765  
Texas City, Texas 77590  
Phone: (409) 948-3094  
Fax: (409) 948-8574  
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