Snohomish Family Chiropractic
Pregnancy Questionnaire

Name:_____

Date:_____

Previous Birth Experience:

Is this your first pregnancy? ____Yes ____No

If not, how many children do you currently have? (ages and names) _____

_____

Please tell us about your previous pregnancy and/or birth experience(s): (duration, interventions, etc.)

_____

_____

Do you plan to follow the same plan as your previous delivery? ____Yes ____No

If not, what would you like to change? _____

_____

Please check if any of these pertain to you:

Pregnant with multiples ___

High risk pregnancy ___

Gestational diabetes ___

High blood pressure ___

Pre-eclampsia ___

Placental dysfunction ___

Breech ___

Transverse ___

Premature labor ___

Pubic pain ___

Low back pain ___

Mid back pain ___

Neck pain ___

Headache ___

Sciatic pain ___

Morning sickness, nausea ___

Heartburn ___

Constipation __

What is your sleep quality? Good / Fair / Poor

Do you exercise currently? Yes / No Type? _____

Have you had any slips, falls, or other physical traumas during the pregnancy? Yes / No

Birth Planning:

How far along are you? _____ What is your expected due date? _____

Did you have difficulty conceiving? If yes, please explain: _____

Obstetrician name & practice if applicable: _____

Midwife name & practice if applicable: _____

Doula name & practice if applicable: _____

Are you taking any prenatal or birthing classes? Where? _____

What type of birth do you intend on having?

Vaginal ___

Cesarian ___

VBAC ___

Where do you intend on having your baby?

Home ___

Birth Center ___

Hospital ___

Do you plan on breastfeeding your child? Yes / No

What do you intend to do for vaccines? _____

What are your goals for this pregnancy?

1._____

2._____

3._____

Is there anything else you'd like to tell us or ask us about your pregnancy or birth plan?

_____

_____

_____