

952.881.2800 office
5143 w 98th street
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Pregnancy Intake Form

Case History for Pregnant Mothers (page 1 of 2)

Name: _____

Date: _____

Prenatal History

Is this your first pregnancy? **Yes / No**

If **No**, how many other births have you had? _____ Year(s): _____

How many weeks pregnant are you now? _____ Due Date: _____

Have you experienced any traumas during this pregnancy? (Accidents, falls, etc.) **Yes / No**

If **Yes**, please describe: _____

Are you taking any medications or supplements during this pregnancy? **Yes / No**

If **Yes**, list what & why for each: _____

Do you smoke or drink alcohol? **Yes / No** If **Yes**, explain: _____

Have you had, or do you have any pregnancy evaluation procedures planned? **Yes / No**

(i.e. - ultrasound, amniocentesis, chorionic villus sampling, etc.)

If **Yes**, please list the procedure & the reason for each: _____

How has your diet been during this pregnancy? **Excellent / Average / Poor**

Have there been any complications in this pregnancy? **Yes / No**

If **Yes**, please describe: _____

What are your most significant fears associated with this pregnancy or birth process? _____

Who is your birth care provider? _____

Will you have someone with you at the birth for coaching or support? **Yes / No**

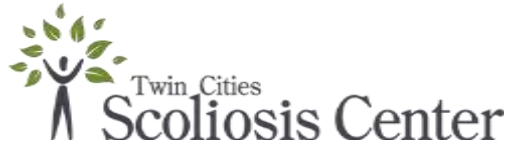
If **Yes**, specify who: _____

Where do you plan on delivering? _____

Do intend to utilize a birth plan? **Yes / No**

If **No**, why? _____

Why are you seeking Chiropractic care during your pregnancy? _____



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Previous Birth History

Place of birth: Hospital / Birthing Center / Home / Other: _____

Delivering Practitioner: OB/Gyn / Nurse Midwife / Certified Practicing Midwife / Lay Midwife

Position of Delivery: Lithotomy position (on back w/ feet up) / On Your Side / Kneeling / Squatting / Birthing Chair / Birthing Tub / Caesarian Section / Other? _____

If Caesarian Section, please explain why: _____

Was labor induced? Yes / No

If Yes, were contractions stimulated prior to the natural onset of labor? Yes / No / Unknown

If Yes, were contractions stimulated after labor had started? Yes / No / Unknown

If Yes, specify type: IV Pitocin / Prostaglandin Gel (applied to cervix) / Unknown

Were your membranes stripped or ruptured? Yes / No / Unknown

Did you utilize any pain medications or anesthesia? Yes / No / Unknown

If Yes, please specify type used:

How many centimeters were you dilated when it was administered? _____

How did it affect labor? _____

Did you experience back pain during labor? Yes / No / Unknown

Baby presentation at time of delivery: Normal / Posterior / Brow / Facial / Breech

If Breech, specify type: Footling / Frank / Complete / Kneeling

Did your care provider assist the delivery with his or her hands? Yes / No / Unknown

If Yes, was there any turning or pulling applied to the baby's neck? Yes / No / Unknown

Was there any visible injury to the baby? Yes / No / Unknown

If Yes, where and how was the baby injured? _____

Were operative devices used to facilitate the birth? Yes / No / Unknown

If Yes, which type? Forceps / Vacuum Extraction / Other: _____

If Yes, were there any visible signs of injury to the baby? Yes / No / Unknown

If Yes, where was the injury sustained? _____

Was there a birthing coach present? Husband / Doula / Friend / Other

At what week of pregnancy was the baby born? _____

Did you have any complications during any of your previous pregnancies? Yes / No

If Yes, please explain: _____

If miscarriages, please list dates and weeks gestation: _____
