Pregnancy Intake

Name *

Date of Birth *

Phone Number *

Email *

Home Address *

Spouse/Partner (Name, Phone Number)

Your occupation

At work, do you primarily

- ☐ Sit
- ☐ Stand
- ☐ Repetitive tasks

Please select any treatments you have had in the past *

- ☐ Chiropractic
- ☐ Acupuncture
- ☐ Massage Therapy
- ☐ Cupping
- ☐ Reiki
- ☐ Physical Therapy
- ☐ Other:

Who is your OBGYN? (Name, Practice, Phone Number) *

How did you hear about us?

Current Health

How far along in your pregnancy are you? *

When is your due date? *

Is this your first pregnancy?

○ Yes ○ No

Have you taken any medications during this pregnancy?

○ Yes ○ No

If yes, please specify

Any physical trauma during this pregnancy?

- Yes
- No

If yes, please specify

Any stressful events in your life during this pregnancy?

- Yes
- No

If yes, please specify

Where do you plan on delivering?

What type of birthcare provider are you planning on using?

- Midwife
- OBGYN
- Medical Doctor

If other, please specify

Did you have any difficulty conceiving?

- Yes
- No

If yes:

- OIUI
- OIVF
- Egg donation
- Sperm donation
- Hormonal imbalance
- PCOS
- Surrogate
- Other:

Any Miscarriages?

- Yes
- No

If yes:

- D&C
- Natural Miscarriage

Have you experienced any of the following symptoms during this pregnancy?

- Headaches
- Carpal tunnel
- Low/Mid back pain
- Nausea/"Morning sickness"
- Chronic fatigue
- Heartburn/Indigestion
- Pain in your pubic bone
- Pins/Needles in front/side of your leg
- Sciatica pain
- Swelling of ankles, legs, and feet
- Leg cramps
- Round ligament pain/pulling
- Constipation
- Hemorrhoids
- Gestational diabetes
- Breech or side-lying
- Preeclampsia
- Facial paralysis

Pregnancy History

(skip if not applicable)

How many children do you have?

How many vaginal deliveries?

How many caesarean deliveries?

Has there been any complications during your previous deliveries? If yes, please specify

Was labor induced/use of pitocin?

- [ ] No
- [ ] Yes
- [ ] Unknown

Did your care provider rupture your membranes?

- [ ] No
- [ ] Yes
- [ ] Unknown

Was your baby in a suboptimal position during the pushing phase of any labor?

- [ ] No
- [ ] Yes
- [ ] Unknown

Hip/back pain during labor?

○ Yes ○ No

Did you receive an epidural?

○ Yes ○ No

Any operative devices used?

- [ ] No
- [ ] Forceps
- [ ] Vacuum

Any postpartum complications or long term consequences?

Your Birth/Post Birth Plan

What are your top three goals for the pregnancy?

Is there anything else you would like to tell us?

Any questions or concerns you want to be sure to ask today?

Patient Signature *

Date *