HISTORY FOR PREGNANT PATIENT

Name _____Date of Birth _____
Home Telephone_____Work Telephone_____
Name of Husband_____Husband's Employment_____
Insurance Information_____
Did a health problem prompt you to visit a chiropractor? Yes/No
Explain _____
Previous Major Illness or Surgery _____
Medications you are currently taken or have taken since conception _____
_____
Allergies_____
Do you smoke? ___ (If no did you ever smoke)?_____ How Long _____
Do you drink? None ____Social (Fewer then 2 daily) ____Heavy (2 or more daily)_____
List the foods you eat daily and summary of your diet habits _____
_____
_____
_____
What type of exercises do you do?_____
Age at last menstrual cycle? ____Length of regular menstrual cycle? _____
Are your cycles regular? Always ____Most of the time _____Never _____
Date of your last menstrual cycle _____Was it normal? _____
Date of last x-rays if any? _____Why and by whom? _____

Have you had any previous pregnancies? Yes/No Please Explain:
_____
_____
Have you had past cesareans? ____How many?_____
Have you had a previous D&C?____How many and dates? _____
Do you have any of the following?
Diabetes____Asthma____Rh negative blood____Other chronic problems_____
Have you taken birth control pills? Yes/No Type _____
Have you used an IUD?_____Date of removal_____
Did you have any health problems during previous pregnancies? Explain _____
_____
_____
Have you ever received chiropractic care?____Dr's. Name_____
Results_____
Who referred you to our office?_____
Name of your obstetrician?_____Nurse/Midwife?_____
Other_____
Where do you plan to have your baby? _____
What symptoms of pregnancy have you already experienced?_____
Additional comments_____