Health History – Prenatal Care

Name: _____ _ _ _____DOB:_____Date:_____

Address: _____City: _____State: _____ Zip: _____

Email: _____Occupation: _____

Phone: _____Cell: _____Work Phone:_____

Married Single Divorced Widowed Kids: _____

Name & Number of Emergency Contact:_____Relationship:_____

How did you hear about the office: _____

Is this your first pregnancy? **Yes** **No** If no, How many Children do you have?_____

Current Pregnancy

Due date/week _____ I am in my _____ week of pregnancy.
Childbirth preparation: **Bradley** **LaMaze** **Hypnobirthing** **Other:**_____
Childbirth caregivers: **OB/GYN** **Doula** **Midwife**
Last visit to caregivers? _____
I plan on giving birth at **Hospital** **Home** **Birth Center**
Name of hospital or birth center? _____
What position do you sleep in? **Side** **Back** **Stomach**
Any traumas during this pregnancy? **Yes** **No**
If yes, please describe_____
Any hospitalizations during this pregnancy? **Yes** **No**
If yes, please describe _____
Any medications during this pregnancy, including over the counter medication? **Yes** **No**
If yes, please describe_____
Any supplements during this pregnancy? **Yes** **No**
If yes, please describe_____
Any fertility treatment? **Yes** **No**
If yes, please describe_____
Do you smoke? **Yes No**
Do you drink alcohol? **Yes No**
How has your diet been this pregnancy? **Excellent** **Average** **Poor**
Has there been any complications during this pregnancy? **Yes** **No**
If yes, please explain_____
Will you have someone with you at the birth for coaching and support? **Yes** **No**
If yes, who?_____
What are your most significant fears associated with this pregnancy or birth process? _____
_____
Why are you seeking chiropractic care during your pregnancy?_____
_____
Any other information you would like us to know about you and your pregnancy? _____
_____

After 32nd week of Pregnancy

Position of baby: **Head down Posterior Breech or Malpositioned**

Confirmed by: Palpation by _____ on ____/_____/_____

Ultrasound by _____ on ____/_____/_____

How long do you believe baby has been in this position? _____

The Webster Technique Defined

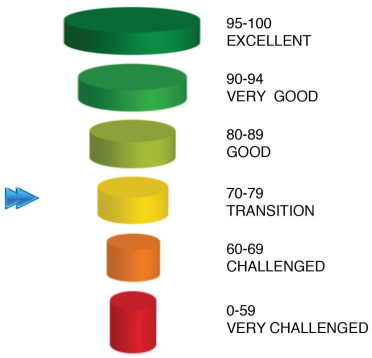
International Chiropractic Pediatric Association definition of Webster Technique:

The Webster technique is a specific chiropractic analysis and adjustment that reduces interference to the nervous system, balances out pelvic muscles and ligaments which in turn removes torsion to the uterus, reducing the potential for intra-uterine constraint and allows the baby to get into the best possible position for birth.

Please check (✓) all symptoms you have ever had, even if they do not seem currently related:

___ Headaches	___ Loss of Balance	___ Numbness in hands	___ Allergies
___ Dizziness	___ Frequent Cold/Flu	___ Numbness in feet	___ Menstrual Cramps
___ Sleeping Problems	___ Ringing in Ears	___ Upset stomach	___ Menstrual Irregular
___ Fatigue	___ Body Tension	___ Constipation	___ Asthma
___ Depression	___ Neck Pain	___ Diarrhea	___ Fainting
___ Irritability	___ Mid Back Pain	___ Urinary Problem	___ Heartburn
___ Mood Swings	___ Low Back Pain	___ Ulcers	
___ Anxiety/Nervousness	___ Pins/ Needles in hands	___ Pins/ Needles in feet	

Please mark an "X" where you believe your health is and an "O" where you would like to be.



I consent to a professional and complete chiropractic examination that the doctor deems necessary. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

I acknowledge that I understand the Office Policies & Procedures and that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information.

Patient Signature: _____ Date: _____