Awaken Life Family Chiropractic, LLC

Pregnancy Health History Form

Patient Name _____ Age _____ Birth Date ____/____/_____

Address _____ City _____ Zip _____

Home phone _____ Cell _____ Work phone _____

Email _____ Single/Married/Divorced (circle one)

Occupation _____ Employed by: _____

Partner's Name/ Occupation_____

No. of Children _____ ; Names/Ages _____

Who may we thank for referring you? _____

Your Health Profile

How many weeks pregnant are you today? _____ Estimated due date? _____

Birth Attendants/Primary Care Providers *Name(s):*

□ Medical Doctor/OB _____

□ Midwife _____

□ Doula _____

Anticipated location of delivery: _____

Check if you: □ Sit more than 4 hours per day □ Drive for more than 2 hours per day

□ Construction or physical labor □ Do repetitive motions throughout the day

Have you ever suffered from….	Before pregnancy	During pregnancy		Before pregnancy	During pregnancy
Nausea/Morning sickness	□	□	Headaches	□	□
Back pain/ Sciatica	□	□	Neck/shoulder pain	□	□
Pubic pain/pressure	□	□	Heartburn	□	□
Diabetes	□	□	Restless or Crampy Legs	□	□
High blood pressure	□	□	Asthma or allergies	□	□

What is your **primary concern** today? _____

If you experience pain, is it: □ Sharp □ Dull □ Comes & goes □ Travels □ Constant

Since the problem started, is it: □ About the same □ Getting better □ Getting worse

What makes it worse? _____ better _____

Does it interfere with: □ Work □ Sleep □ Walking □ Sitting □ Hobbies □ Leisure

List any ***medications***, ***vitamins*** or ***supplements*** you are taking _____

_____

Have you had ***surgery*** or been ***hospitalized***? (circle) If yes, please explain _____

_____

Have you had a ***fall - accident - injury***? (circle) If yes, please explain _____

_____

Any previous **chiropractic care?** Yes/No (circle). Last adjustment? _____ Reason for leaving? _____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Signature _____ Today's Date _____