

Case History for Pregnant Mothers

(To be completed *in addition* to the adult intake form and pregnancy Terms of Acceptance.)

Name: _____ Date: _____

Prenatal History:

- 1) Is this your first pregnancy? **Yes / No**
If **No**, how many other births have you had? _____ **Year(s):** _____
- 2) How many weeks pregnant are you now? _____ **Due Date:** _____
- 3) Have you experienced any traumas during this pregnancy? (Accidents, falls, etc) **Yes / No**
If **Yes**, please describe: _____
- 4) Are you taking any medications or supplements during this pregnancy? **Yes / No**
If **Yes**, list what & why for each: _____
- 5) Do you smoke or drink alcohol? **Yes / No** If **Yes**, explain: _____
- 6) 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: _____

- 7) How has your diet been during this pregnancy? **Excellent Average Poor**
- 8) Have there been any complications in this pregnancy? **Yes / No**
If **Yes**, please describe: _____
- 9) What are your most significant fears associated with this pregnancy or birth process? _____

- 10) Who is your birth care provider? _____
- 11) Will you have someone with you at the birth for coaching or support? **Yes / No**
If **Yes**, specify who: _____
- 12) Where do you plan on delivering? _____
- 13) Do intend to utilize a birth plan? **Yes / No**
If **No**, why? _____
- 14) Why are you seeking Chiropractic care during your pregnancy? _____

Previous Birth History:

- 1) Place of birth: **Hospital / Birthing Center / Home / Other:** _____

- 2) Delivering Practitioner: **OB/Gyn / Nurse Midwife / Certified Practicing Midwife / Lay Midwife**

- 3) 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: _____

- 4) 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**

- 5) Were your membranes stripped or ruptured? **Yes / No / Unknown**

- 6) 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? _____

- 7) Did you experience back pain during labor? **Yes / No / Unknown**

- 8) Baby presentation at time of delivery: **Normal / Posterior / Brow / Facial / Breech**
If **Breech**, specify type: **Footling / Frank / Complete / Kneeling**

- 9) 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**

- 10) Was there any visible injury to the baby? **Yes / No / Unknown**
If **Yes**, where and how was the baby injured? _____

- 11) 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? _____

- 12) Was there a birthing coach present? **Husband / Doula / Friend / Other**

- 13) At what week of pregnancy was the baby born? _____

- 14) 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: _____
