THE NATURAL HEALTH IMPROVEMENT CENTER ST. JOSEPH

Dr. Katie Stull • Wellness, Chiropractic & Nutrition Response Testing
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PREGNANT MOTHERS INTAKE FORM

Name _____
Age _____
Have you previously received Chiropractic care? Yes / No
Who referred you to our office _____

Prenatal History
Is this your first pregnancy? Yes / No
How many births have you had _____
How many weeks are you pregnant now _____
Have you experienced any traumas (accidents/falls) during this pregnancy?
Yes / No Please explain _____
Any medications taken during this pregnancy
_____
Do you smoke or drink alcohol Yes / No
Have you had any evaluation procedures (ultrasound, amniocentesis, chorionic villus sampling) Yes / No
Please list dates, frequency and reason
_____
How has your diet been during this pregnancy _____
Have there been any stressful events in your life during this pregnancy
_____
What are your most significant fears associated with this birth
_____
Who is your birth care provider _____
Will you have someone with you at birth for support (other that birth care provider) Yes / No Please specify who _____
Where do you plan on delivering _____
Have you put together a birth plan _____
Previous Birth History
Place of birth Hospital / Birthing Center / Home
Delivering Practitioner OB Gyn / Cert Nurse Midwife / Cert Pract Midwife / Lay Midwife
Position of Delivery Lithotomy position (on back with feet up) / On your side / Kneeling / Squatting / Other _____

Was labor induced (contractions were stimulated *prior* to the natural onset of labor) **Yes / No / Unknown**

If yes, specify type Pitosit / Prostagland Gel (applied to your cervix) **/ Unknown**

Were your membranes ruptured by your care provider Yes / No / Unknown

Were contractions stimulated intravenously with pitocin *once* labor starterd Yes / No / Unknown

Did you receive any pain medications or anesthesia Yes / No / Unknown

Please specify type used _____

If you had an epidural, how many cm. were you dilated when administered _____

Did you experience back pain during labor Yes / No / Unknown

Did you deliver vaginally Yes / No

Baby presentation at time of delivery Normal / Posterior / Brow / Facial / Breech

If breech, specify type Footling / Frank / Complete / Kneeling

Was there any visible injury to your baby Yes / No / Unknown

If so, where on your baby was the injury sustained _____

Did the care provider assist delivery with his/her hands Yes / No / Unknown

Was there any turning of the neck or traction (pulling) applied to the neck Yes / No / Unknown

Were operative devices used to facilitate the birth Yes / No / Unknown

Which types Forceps / Vacuum Extraction

If yes, were there any visible signs of injury to your baby Yes / No / Unknown

If yes, where was the injury sustained _____

Was there a birthing coach present Husband / Doula / Friend / Other

If other, please specify _____

At what week of pregnancy was your baby born _____