Morsch Family Chiropractic

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Pregnancy Health Form

Date: _____ Social Security #: _____

Patient's Name: _____ Date of Birth: _____

Names and ages of other children: _____

Provider: ☐Mid- Wife ☐ OB-Gyn ☐Other: _____

Provider's contact info: _____

How far along in the pregnancy are you? _____ weeks When is your due date? _____

# of previous pregnancies: _____ Any complications with previous pregnancies? ☐Yes ☐No
If yes, please explain: _____

During your current pregnancy, did you have any of the following?

Yes	No		Please describe:
☐	☐	Falls	_____
☐	☐	Motor Vehicle Accident	_____
☐	☐	High Blood Pressure	_____
☐	☐	Diabetes	_____
☐	☐	Anemia	_____
☐	☐	Morning Sickness	_____
☐	☐	Indigestion	_____
☐	☐	Seizures	_____
☐	☐	Swollen Ankles	_____
☐	☐	Thyroid Problems	_____
☐	☐	Heart Problems	_____
☐	☐	Back Pain	_____
☐	☐	Abnormal Bleeding	_____
☐	☐	Hospitalization	_____
☐	☐	Other	_____

During your pregnancy, are you using any of the following:

Yes	No		Please describe/list
☐	☐	Tobacco	_____
☐	☐	Alcohol	_____
☐	☐	Non-prescribed drugs	_____
☐	☐	Prescribed medications	_____
☐	☐	Vitamins/ Supplements	_____

Has the baby been in a breech position? ☐Yes, currently ☐Yes, previously ☐No ☐Don't know

Have you had an ultrasound done? ☐Yes ☐No

Have you been to a chiropractor before? ☐Yes ☐No
If yes, for what? _____

Is there anything you are worried about? _____

Is there anything you want more information about? _____

Is there anything else you want the doctor to know? _____
_____