Pregnancy Questionnaire

Patient Information
Name (Last, First): _____
Date of birth: __/__/____
Today's date: __/__/____

Current Pregnancy
Due date/week: _____ Current week: _____
Pre-pregnancy weight: _____ Current weight: _____
Childbirth caregiver(s): □ OB/GYN □ □ Midwife □ Doula □ Maternal/Fetal
Where do you plan on giving birth? □ Hospital □ Birth Center □ Other _____
Name of hospital/birth center? _____
Are you exercising during your pregnancy? □ Yes □ No
If yes, please provide details: _____ days/week; form of exercise _____
Have you experienced any traumas this pregnancy? □ Yes □ No
If yes, please provide details: _____
Have you had any hospitalizations this pregnancy? □ Yes □ No
If yes, please provide details: _____
Are you taking any prescription medications? □ Yes □ No
If yes, please provide details: _____
Are you taking any supplements? □ Yes □ No
If yes, please provide details: _____
Have you undergone any fertility treatments? □ Yes □ No
If yes, please provide details: _____
Have you had an chiropractic care during this pregnancy? □ Yes □ No
If yes, please provide details: _____
Please provide any additional information you would like us to know about this pregnancy:
_____
_____

Beyond the 32nd Week of Pregnancy
Current position of baby: □ Head down □ Posterior □ Breech/malposition
Position confirmed by: □ Palpation: __/__/____ □ Ultrasound: __/__/____
How long has the baby been in this position: _____

Erin Houseknecht, D.C. | Jason Stugart, D.C
Belmont Chiropractic
44115 Woodridge Pkwy, Ste 150
Leesburg, Virginia 20176
P: (571) 291-9359
Email: belmont.chiro.clinic@gmail.com
Website: www.belmontchiroclinic.com

Pregnancy Questionnaire

Previous Pregnancies
Number of previous pregnancies: _____ Number of birth(s): _____ Please explain any difference in the numbers: _____ Years of previous birth(s): _____ Where did the previous birth(s) take place? _____ Medication(s) used during previous birth(s): _____ Interventions used in previous birth(s): _____ How long was your previous labor? Total: _____ Time before you pushed: _____ Amount of time you spent pushing: _____ Did you receive chiropractic care during your previous pregnancy? _____ Any additional information you would like us to know about your previous pregnancy? _____ _____

Patient Signature	
By signing this form, I verify that all of the information is correct to the best of my knowledge and I have completed all the questions with as much information as possible.	
Patient Signature	*Date Signed*

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