RECONNECT
CHIROPRACTIC

Prenatal Questionnaire

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First):*				**Weeks of gestation:**
How did you hear about us?				**Estimated Due Date:**
PRENATAL HEALTH HISTORY QUESTIONS				
Did you have trouble conceiving?	▫ Yes ▫ No If yes, please explain?			
Have you been on any contraceptives? If so, please list and duration you used them?				
Is this your first pregnancy? If no, please list any complications/ interventions and what year?				
Year	**Complication/ Intervention/**			**How long did you carry?**
Do you have a current birth plan: If so, circle all that apply for your specific plan.				
Location:	Hospital	Birth Center	Home	List Location:
Assistance:	Doula	Midwife	OB/GYN	Name of Provider:
Induction:	▫ Yes ▫ No			Scheduled:
Pain Management:	Massage	Epidural	Birthing Tub	Chiropractic Acupuncture
Type:	Vaginal	C-Section		
Labor Preferences:	Walk freely	Birthing ball/Stool/Chair	Eat and Drink as needed	Other/ Positioning:
Have you ever been adjusted while pregnant?				Yes ▫ No ▫
What are your goals for this pregnancy?				
During this pregnancy have you:				**Type and how often:**
Exercised	Yes ▫	No ▫		
Consumed Alcohol	Yes ▫	No ▫		
Smoked	Yes ▫	No ▫		
Consumed Coffee	Yes ▫	No ▫		
Received any Vaccines	Yes ▫	No ▫		
Please circle if, since being pregnant, you have experienced these symptoms:				
Acid Reflux	Carpal Tunnel (numbness in hands)			Increased headaches
Back pain	Increased Bloat/ Gas			Nausea How frequently:
Sciatica	Constipation			Change in Blood Pressure

Patient Signature: _____ **Date:**_____

Doctor Signature: _____ **Date:**_____