Adelaide Chiropractic Centre

Level 3, 55 Gawler Place, Adelaide, South Australia 5000
Telephone (08) 8221 6262

Pregnancy Health History

Name ..... Birth Date ..... Age .....
SURNAME FIRST NAMES

Address ..... Phone No (W) .....

..... Phone No (H) .....

..... Mobile No .....

Marital Status ..... Children .....

Occupation ..... Employer .....

Who recommended you to this centre? .....

Health Cover YES ❑ NO ❑ Fund ..... Workcover YES ❑ NO ❑ Motor accident YES ❑ NO ❑

General	
Convulsions	
Dizziness	
Fatigue	
Headaches	
Loss of Sleep	
Nervousness/Depression	
Cancer	
Diabetes	

Women Only	
Excessive menstrual flow	
Irregular cycle	
Breast lumps	
Menopausal symptoms	
Painful menstruation	
Pre-Menstrual Tension	

Muscle & Joint	
Arthritis	
Low back pain	
Neck pain or stiffness	
Pain between shoulders	

Respiratory	
Chest pain	
Chronic cough	
Difficulty breathing	
High blood pressure	
Asthma	

Cardio-Vascular	
High blood pressure	
Poor circulation	
Varicose veins	

Gastro-Intestinal	
Constipation	
Indigestion	
Gall-bladder trouble	
Nausea/Vomiting	
Stomach Pain	
Haemorrhoids	

Eyes, Ears, Nose & Throat	
Ear ache	
Ear noises	
Eye pain	
Hay fever	
Sinus infection	
Sore throat	

Genito-Urinary	
Bed wetting	
Blood in urine	
Frequent urination	
Kidney infection or stones	
Painful urination	

Pain or numbness in:	
Shoulders	
Arms/elbows	
Hands	
Hips	
Legs	
Knees	
Feet/ankles	
Spinal curvature	

Do you smoke? NO ❑ YES ❑ How many per day? .....

How much alcohol do you drink per week? .....

Accidents (serious) .....

.....

Hospitalization/Operation .....

.....

List current medication .....

.....

Date of last Chiropractic visit ..... Name of Chiropractor .....

What is your major complaint? .....

.....

List previous diagnosis and treatment you have received for this complaint .....

.....

Sporting activities and/or leisure pastimes .....

Signature ..... *Date* .....

Weeks pregnant: ..... **Estimated due date:** .....

In order for us to support you best, please let us know more about your current circumstances:

Why are you here today? *(Answer 1, 2 and/or 3#)*

1. For advice on a particular health crisis *(include how long you have experienced it for)*?

   .....

2. To prevent a potential health issue *(include whether you have experienced it before)*?

   .....

3. To strengthen your health? .....

How would your currently rate your health *(if 10 is exceptional and 1 is poor)*?

1 2 3 4 5 6 7 8 9 10 *(circle number)*

Have you seen a chiropractor previously? YES ❑ NO ❑

If yes, with whom and what was the date of your last visit?

.....

Was this a planned pregnancy? YES ❑ NO ❑

Are you currently receiving prenatal care from a midwife, obstetrician or both?

With whom specifically? .....

.....

In which hospital or birth centre are you planning to have your baby?

Or are you p**lanning a home birth?** .....

What type of birth are you planning? .....

Are you planning to attend any birth classes? Which ones?

.....

Have you received information or advice regarding your pending birth?

If so, what advice and by whom? .....

.....

Do you have a birth plan? YES ❑ NO ❑

If this is a subsequent pregnancy and birth for you, how do you feel about your previous birth experience? Delighted ❑ Neutral ❑ Disheartened ❑

Comment: .....

How do you feel about your pending birth? Frightened ❑ Anxious ❑ Excited ❑

Comment: .....

What vision do you have for this labor?

Please describe: .....

Do you feel supported in your birth choices (eg: by your partner, family, health practitioners)**?**

YES ❑ NO ❑

Are you currently taking any medication (eg: antibiotics or over-the-counter drugs such as Panadol)?

YES ❑ NO ❑

Have you taken any medication during this pregnancy? YES ❑ NO ❑

If yes, please specify: .....

Have you had any vaccines during your pregnancy? YES ❑ NO ❑

How often are you currently consuming alcohol?

Each day ❑ Each week ❑ Every few weeks ❑ Rarely ❑ Never ❑

Do you or other people around you smoke? YES ❑ NO ❑ *If yes, how frequently?* .....

Are you experiencing any emotional stress *(eg: relationship, family, financial, or career challenges)***?**

YES ❑ NO ❑ *If yes, can you elaborate?* .....

What clinical tests have you had to date *(eg: tests to establish if you or your baby has any health risks)***?**

.....

Please tick any of the following which relate to your current pregnancy:

❑ Any hospitalization	❑ Medications	❑ Excessive fatigue
❑ Mood swings	❑ Depression	❑ Infections
❑ Urinary infections	❑ Blood in urine	❑ Blood in stool
❑ Protein in urine	❑ High blood pressure	❑ Pre-eclampsia
❑ Eclampsia	❑ Seizures	❑ Gestational diabetes
❑ Heart problems	❑ Thyroid issues	❑ Placental issues

❑ Pelvic inflammatory Disease ❑ Abnormal bleeding ❑ Circulatory problems

❑ Swollen ankles ❑ Low blood pressure ❑ Anemia

❑ Yeast infection ❑ Indigestion ❑ Other illness

.... *(please specify)*

Have you experienced any of these in previous pregnancies?

.....

.....

.....

Have you had any ultrasounds to date? YES ❑ NO ❑ *If yes, how many?* .....

Findings? .....

.....

.....

Are you aware of the current position of your baby *(eg: head down, transverse)***?**

.....

Have you had advice on optimal posture during your pregnancy? *If so, what advice?*

.....

Do you enjoy being pregnant? YES ❑ NO ❑

How can we support you best during your pregnancy?

.....

.....

.....

Do you have any other comments or questions?

.....

.....

.....

.....

.....

Signature ..... *Date* .....