Pregnant PATIENT Additional Information:

Name: _____ DOB/Age: _____/____ Date: _____

Obstetrician? [ ] _____ Midwife? [ ] _____

Provider's phone number: _____ Fax# _____

Facility planned for delivery [ ]: _____ or Home Birth plan for delivery [ ]

Estimated Date of Delivery (EDD): _____ Current number of weeks: _____

Is this your first child? Yes No **# 2 3 4 5 6 7 8 9 10 11 12 ?? __**

Are you considered a high risk pregnancy? **No Yes**; Explain: _____

Do you have any restrictions at this time? **No Yes**; Explain: _____

Miscarriages? **No Yes**; When? _____ @ what week? _____

Current Medical conditions? **None Yes**; _____

Vitamins/Prenatals? Brand? _____

Medications/ Prescriptions? **None Yes**; _____

Have you had chiropractic care with any of your pregnancies? **No Yes**; Provider _____

History/Interventions with other pregnancies: please let us know some details about other deliveries and pregnancies

Baby #	Name: M/F	Induction? How…	Water broken artificial/spontaneous	Pitocin / Other	Epidural/ Anesthesia	Cesarean Section? Reason	Weeks' gestation	Comments

Is there anything else you would like us to know? _____

Patient Signature: _____ **Date:** _____