Prenatal Patient Questionnaire

Note: Fill out this questionnaire at your own convenience. Your answers are saved as you go, so you don't need to finish it all in one sitting.

Submit the form only when you have answered all that you can.

1

CONFIDENTIAL PATIENT INFORMATION

First Name:

Last Name:

Date of Birth:

Gender:
○ Female

Height (ft, in):

Weight (lbs):

Your Occupation:

Street Address:

Apt./Unit #:

City:

State:

Zip Code:

Marital Status:
○ Single ○ Married ○ Divorced ○ Widowed

Name of Spouse:

# of Children:

Name(s) of Children:

Email:

Cell Phone:

Preferred Method of Contact: (select all that apply)
☐ Text message ☐ Phone Call
☐ Email

Other Phone:

How did you hear about us?

2

Emergency Contact:

Emergency Relation:

Emergency Phone:

5

Who is your primary care physician?

Date of your last visit:

Reason for your last doctor visit:

Address of your primary care physician?

6
What other healthcare providers are you currently seeking care from for this condition?

	Name	Specialty
1		
2		

CURRENT HEALTH CONDITIONS

7
What primary health concern brings you into our office?

When did this condition first begin?

How did this problem start?

Is this condition:

How often is this present?

Severity:

Have you received care for this problem before?
○ Yes ○ No

How would you describe this pain? (select all that apply)
☐ Sharp ☐ Dull ☐ Ache ☐ Sore ☐ Spasm ☐ Numbness ☐ Tingling ☐ Burning ☐ Shooting ☐ Throbbing ☐ Stiff
☐ N/A

What makes the problem better?

What makes the problem worse?

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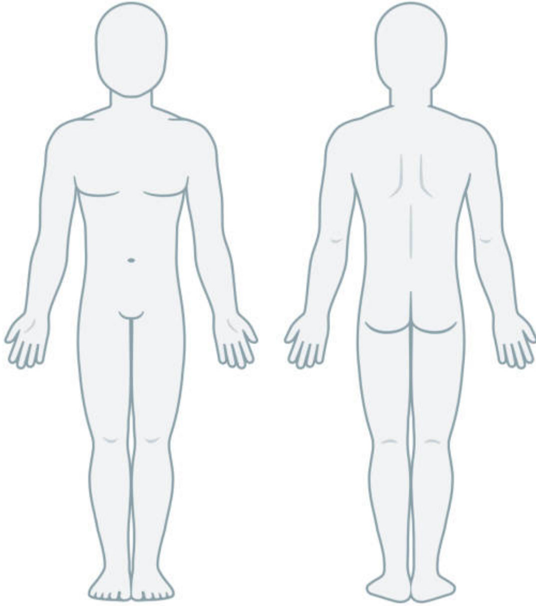
	Other Health Concerns	Severity (1-10)	How long have you had this?	Did this start with an Injury?	Have you had this before?	Constant or Comes/Goes
1						
2						

9

Please indicate which type and where you are experiencing your primary health concern.

Pain | Numbness | Stiffness



10

Please list any significant family medical history:

11

Do you have any health concerns for other family members today?

○ Yes ○ No

If yes, which family members?

YOUR HEALTH GOALS

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Please fill out what your immediate, short-term, and long-term health goals are.

1. What are your immediate health goals?
2. What are your short-term health goals?
3. What are your long-term health goals?

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What would you like to gain from chiropractic care?

○ Resolve existing challenge ○ Overall wellness ○ Both

CHIROPRACTIC HISTORY

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Have you ever visited a chiropractor before?
○ Yes ○ No

If yes, which practice(s)?

When was your last visit?

TRAUMAS: Physical Injury History

15
Have you ever had any significant falls, or surgeries as an adult?
○ Yes ○ No

If yes, please explain:

16
Any auto accidents?
○ Yes ○ No

If yes, please list (include type and year):

17
Did you participate in any youth or college sports?
○ Yes ○ No

If yes, please list any major injuries:

18
Notable childhood injuries?
○ Yes ○ No

If yes, please explain:

TOXINS: Chemicals & Environmental Exposure

19
Please rate your consumption for each:

	1 - None	2	3 - Moderate	4	5 - High
Water	○	○	○	○	○
Alcohol	○	○	○	○	○
Cigarettes	○	○	○	○	○

20
Are you taking any medications?
○ Yes ○ No

If yes, please list medication, dosage and reason:

	Medication	Dosage	Reason
1			
2			

21
Are you taking any vitamins and/or supplements?
○ Yes ○ No

If yes, please list vitamin/supplement, dosage, and reason.

	Vitamin/Supplement	Dosage	Reason
1			
2			

THOUGHTS: Emotional Stresses & Challenges

22
Please rate your stress for each:

	1 - None	2	3 - Moderate	4	5 - High
Home	○	○	○	○	○
Work	○	○	○	○	○
Life	○	○	○	○	○
Money	○	○	○	○	○
Health	○	○	○	○	○
Family	○	○	○	○	○
Other	○	○	○	○	○

If "other", please list here:

23
Are there other emotional stresses or challenges you'd like to tell us about?

LIFESTYLE

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Do you wake up:
○ Refreshed and ready ○ Stiff and tired

How many hours do you sleep on average?
☐ Less than 5 hours ☐ 6-7 hours ☐ 8 or more hours

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Exercise Frequency?

What types of exercises?

26
How many hours per day do you typically spend sitting at a desk, in a car, or on an electronic device?

Click the right arrow to continue to the next page...

Pregnancy Questionnaire

Congratulations on your pregnancy! It is important for us to know your past history and current goals, so having the following information will help us best take care of you.

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CONCEPTION AND EARLY PREGNANCY:

When is your expected or calculated due date?

28

Have you experienced morning sickness?

○ Yes ○ No

If yes, please explain:

29

Have you taken any medications or supplements during your pregnancy?

○ Yes ○ No

Please List:

	Medication/Supplement Name	Dosage	Frequency	Reason for Taking
1				
2				

30

Have you used any hormonal or oral contraceptives?

○ Yes ○ No

Which ones, and how long?

Your Birth Plan

31

Your top three goals for this pregnancy:

1.

2.

3.

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PREVIOUS BIRTH EXPERIENCE:

Is this your first pregnancy?
○ Yes ○ No

Please tell us about your first pregnancy(ies) and/or birth experience(s):

Regarding your first pregnancy(ies), did you have difficulty conceiving?
○ Yes ○ No

If yes, please describe:

Do you plan to follow the same birth plan as your previous delivery(ies)?
○ Yes ○ No ○ This is my first pregnancy

If yes, what would you like to change?

Do you currently have any birth plans?
○ Yes ○ No

If yes, please explain:

Are you taking any pre-natal or birthing classes?
○ Yes ○ No

If yes, where?

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DELIVERY PLANS:

Do you intend to have a doula or birth coach present
○ Yes ○ No

Who is your OB/GYN or midwife?

Will they be present for delivery?

Who is your birth provider?

Would you be interested in getting connected with a doula?
○ Yes ○ No

Do you wish to have a natural vaginal labor and delivery?
○ Yes ○ No

What concerns do you have?

Your Post-Birth Plan

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Do you plan on breastfeeding your child?
○ Yes ○ No

What do you intend to do for vaccines?

Would you like additional resources regarding vaccines?
○ Yes ○ No

Is there anything else you'd like to tell us about your pregnancy or birth plan?

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Are there any other questions you want to ask us?

Click the right arrow to continue to next page...

Patient Review of Systems

The nervous system controls and coordinates all organs and structures of the human body.

Please check the corresponding boxes for each symptom or condition you have experienced - including both past and present.

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CARDIOVASCULAR

	Past	Present
Blood Clots	☐	☐
Cold / Blue Fingers or Toes	☐	☐
Chest Pain	☐	☐
Heart Palpitations	☐	☐
High Blood Pressure	☐	☐
Swelling in Hands / Feet	☐	☐

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CONSTITUTIONAL

	Past	Present
Fever	☐	☐
Night Sweats / Chills	☐	☐
Sudden Weight Loss or Gain	☐	☐

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HEENT

	Past	Present
Ear Infections	☐	☐
Ringing in Ears	☐	☐
Sinus Congestion	☐	☐
Sore Throat	☐	☐
TMJ / Jaw Pain	☐	☐
Vertigo	☐	☐

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IMMUNOLOGIC

	Past	Present
Autoimmune Condition	☐	☐
Food Intolerance / Seasonal Allergies	☐	☐
Eczema / Skin Conditions / Rash	☐	☐

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GASTROINTESTINAL

	Past	Present
Acid Reflux / Heartburn	☐	☐
Abdominal Pain / Bloating / Swelling	☐	☐
Constipation / Diarrhea	☐	☐
Nausea / Vomiting	☐	☐

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GENITOURINARY

	Past	Present
Bladder & Urination Issues	☐	☐
Fertility Challenges	☐	☐
Ovarian / Uterine Issues	☐	☐
Prostate Issues	☐	☐

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MUSCULOSKELETAL

	Past	Present
Arthritis	☐	☐
Joint Stiffness	☐	☐
Muscle Weakness / Cramping	☐	☐

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NEUROLOGIC

	Past	Present
Concussions	☐	☐
Headaches / Migraines	☐	☐
Incoordination	☐	☐
Numbness / Tingling Sensations	☐	☐
Paralysis	☐	☐
Seizures	☐	☐
Syncope / Fainting	☐	☐
Tremors	☐	☐

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PSYCHOLOGICAL

	Past	Present
ADHD	☐	☐
Anxiety	☐	☐
Depression	☐	☐
Focus / Attention / Concentration Issues	☐	☐
Sleeping Difficulties	☐	☐

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RESPIRATORY

	Past	Present
Asthma	☐	☐
Bronchitis or Pneumonia	☐	☐
Chronic Cough / Colds	☐	☐
Emphysema	☐	☐
Pneumonia	☐	☐
Shortness of Breath	☐	☐
Wheezing	☐	☐

ACKNOWLEDGEMENT & CONSENT

By signing this form electronically, and clicking on "Submit Signature", you are agreeing to the terms stated herein.
e-signature

Signature: ______________________ Date: ______________