VITA CHIROPRACTIC

Name: _____ Date of Birth:____/____/_____

PREVIOUS BIRTH EXPERIENCE

Is this your first pregnancy? ☐ Yes ☐ No
If no, how many pregnancies previously? _____ What about miscarriage(s)? _____
How many children do you have? _____
How many vaginal deliveries? _____ How many cesarean deliveries? _____
Was labor induced using Pitocin? ☐ No ☐ Yes ☐ Unknown
Was there any hip or back pain during labor? ☐ No ☐ Yes
Was baby in a problematic position during the pushing phase of labor? ☐ No ☐ Yes ☐Unknown
Did you receive an epidural? ☐ No ☐ Yes
Were there any operative devices used? ☐ No ☐ Yes, if yes: ☐ Forceps ☐ Vacuum
Did you experience any postpartum complications or long-term consequences? ☐ No ☐ Yes _____
_____
Any other details you would like to provide? _____
_____

Do you plan to follow the same plan as your previous delivery/deliveries? ☐ No ☐ Yes
If not, what would you like to change? _____
_____

CONCEPTION & EARLY PREGNANCY

When is your expected or calculated due date? ___/___/____ How many weeks are you? _____
Gender: Boy☐ Girl☐ Surprise☐ Unknown☐

Did you have any difficulty conceiving? ☐ No ☐ Yes
If yes, please explain:

Have you used any form of hormonal contraceptives? ☐ No ☐ Yes
If yes, which ones and how long?

Have you experienced morning sickness? ☐ No ☐ Yes
If yes, please explain:

CURRENT HEALTH CONDITIONS

Have you had any major emotional stressors during this pregnancy? ☐ No ☐ Yes
If yes, please explain: _____
_____

Please tell us about your current diet, and any dietary restrictions: _____
_____

have you taken any medications or supplements during your pregnancy? ☐ No ☐ Yes
If yes, please explain:

_____ _____ _____

PRINT SIGN DATE