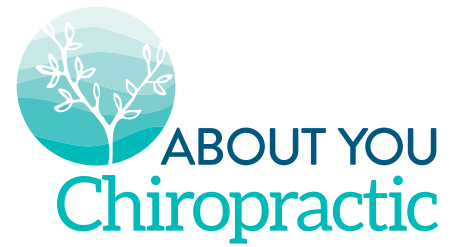


CONFIDENTIAL CURRENT PREGNANCY HISTORY



Name: (Mrs/Ms/Miss/Mr/Dr) _____ Date: _____

What number pregnancy is this? _____ How many weeks? _____

Estimated due date: _____

Was conception: Natural or Assisted (please tick) _____

Do you plan to breast feed? Yes No Are you currently breastfeeding? Yes No

Childbirth carers (please tick): Doula Midwife OB/GYN Other Undecided

Name/s of caregivers: _____

I plan on giving birth: At Home Birth Centre Hospital Other Undecided

Currently working? Yes No How many hours/days? _____

When do you plan to start maternity leave? _____ For how long? _____

Please tick any of the following that apply to you: _____

- | | | | | |
|-------------------------|---------------------|--------------|----------------------|--------------------|
| Difficulties conceiving | Vaginal bleeding | Any falls | Gestational diabetes | Swelling |
| Hospitalisations | Trauma | High stress | Pre-eclampsia | Protein in urine |
| Ultrasounds | Motor accidents | High anxiety | Previous c-section | Vaccines |
| Morning sickness | Amniocentesis / CVS | Hemorrhoids | High blood pressure | Recreational drugs |
| Miscarriages | Exercise | Fainting | Depression | Alcohol / smoking |

Are you aware of any health concerns in this pregnancy / previous pregnancies? Please click on line below if filling out electronically. _____

Are you taking any medications? (Including over the counter / Vitamins / Supplements): Yes No If yes, please list: _____

Have you had chiropractic care during this pregnancy? Yes No If yes when was last adjustment? _____

Have you had chiropractic care during previous pregnancies? Yes No _____

What other health practitioners have you consulted during this pregnancy? Please click on line below if filling out electronically. _____

Is there anything else you would like us to know about you and your pregnancy? Please click on line below if filling out electronically. _____