Total Family Wellness
Quality Chiropractic Care for the Whole Family

2070 Northbrook Blvd. Suite B5, North Charleston, SC 29406 **(843)641-7075**

Pregnant Mothers Intake Form

Name: _____
Age: _____
Have you previously received chiropractic care: __Yes / No__
Who referred you here: _____

Prenatal history:

1. Is this your first pregnancy? __Yes / No__
2. How many other births have you had? _____
3. How many weeks pregnant are you now? _____ weeks
4. Have you experienced any traumas (accidents, falls) during this pregnancy? __Yes / No_____
   Please describe: _____
5. Any medications taken during this pregnancy? _____
6. Do you smoke or drink alcohol? __Yes / No_____
7. Have you had any evaluation procedures (ultrasound, amniocentesis, chorionic villus sampling)?
   _____
8. Please list dates, frequency and reason for these procedures: _____
   _____
9. How has your diet been during this pregnancy? _____
10. Have there been any stressful events in your life during this pregnancy? _____
    _____
11. What are your most significant fears associated with this birth? _____
    _____
12. Who is your birth care provider? _____
13. Will you have someone with you at birth for support (other than birth care provider)? __Yes / No__
    Please specify who: _____
14. Where do you plan on delivering? _____
15. Have you put together a birth plan? _____

Previous Birth History:

1. Place of birth: Hospital / Birthing Center / Home /_____
2. Delivering Practitioner: OB/Gyn, Certified Nurse Midwife, Certified Practicing Midwife, Lay Midwife
3. Position of Delivery: Lithotomy position (on back with feet up) / On Your Side / Kneeling /
   Squatting / Other / _____
4. Was labor induced (contractions were stimulated *prior* to the natural onset of labor): Yes / No
   a. If yes, specify type: Pitocin / Prostagland Gel (applied to your cervix) / Unknown
5. Were your membranes ruptured by your care provider? Yes / No / Unknown
6. Were contractions stimulated intravenously with pitocin *once* labor started?: Yes / No Unknown
7. Did you receive any pain medications or anesthesia? Yes / No / Unknown
   a. Please specify type used: _____
   b. If you had an epidural, how many cm. were you dilated when it was administered: ____ cm
8. Did you experience back pain during labor? Yes / No / Unknown
9. Did you deliver vaginally? Yes / No
10. Baby presentation at time of delivery: Normal / Posterior / Brow / Facial / Breech
    a. If breech, specify type: Footling / Frank / Complete / Kneeling
    b. Was there any visible injury to your baby? Yes / No / Unknown
    c. If so, where on your baby was the injury sustained? _____
11. Did your care provider assist delivery with his/her hands? Yes / No / Unknown

a. Was there any turning of the neck, or traction applied to the neck? Yes/No/Unknown

12. Were operative devices used to facilitate the birth? Yes / No / Unknown
    a. Which type? Forceps / Vacuum Extraction
    b. If yes, were there any visible signs of injury to your baby? Yes / No / Unknown
    c. If yes, where was the injury sustained? _____
13. Was there a birthing coach present? Husband / Doula / Friend / Other___
    a. If other, please specify: _____
14. At what week of pregnancy was your baby born? _____