STRATFORD
Chiropractic
&Wellness
CENTRE

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Supplemental History Form for Pregnancy

Name _____ Date of Birth_____ Age____ Date _____

Current History

Who is your prenatal caregiver? ☐ Midwife _____ ☐ Obstetrician _____
Are you planning to give birth ☐ At Stratford General Hospital ☐ At home
☐ Other hospital _____

When is your due date? _____ How many weeks are you now?_____
What is your due date based on? ☐ Ultrasound – when?_____ ☐ Known conception time
☐ Other_____

Is this your ☐ First ☐ Second ☐ Third+ Pregnancy?

Have you had any of the following symptoms during pregnancy?
Pelvic pain Pelvic pressure High blood pressure Vaginal bleeding Pubic joint pain Rib pain
Other _____

Past Health History

Have you had any previous miscarriages ☐ No ☐ Yes
Date & reason (if known)_____

Did you have any complications with previous pregnancies? ☐ No previous pregnancies
☐ Hypertension ☐ Gestational diabetes ☐ Breech baby ☐ Back pain ☐ Other _____

Did you have any complications with previous deliveries? ☐ No previous deliveries
☐ C-section ☐ Epidural used ☐ Forceps used ☐ Vacuum extraction used
☐ Other _____

Before pregnancy, was your menstrual cycle: Regular Irregular
Did you have any of the following menstrual symptoms?
Heavy flow Abdominal bloating Mild cramps Severe cramps
Endometriosis Low back pain PMS