STRATFORD
Chiropractic
&Wellness
CENTRE

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Supplemental History Form for Pregnancy

Patient Name _____ Date _____
Date of Birth (D/M/Y) _____

Current History

Who is your prenatal caregiver? ☐ Midwife _____ ☐ Obstetrician _____
Where are you planning to give birth?
☐ 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 taken a Prenatal Class? location _____
Have you done any Prenatal specific exercises/yoga/massage?_____
Do you plan to Breastfeed this baby? _____
Have you had any of the following symptoms during pregnancy?
☐ Pelvic pain ☐ Pelvic pressure ☐ Pubic Pain ☐Lower Back Pain ☐ High blood pressure ☐ Vaginal bleeding
☐ Pubic joint pain ☐ Rib pain
☐ Other _____
Do you know the current position of your baby? ☐ Breech ☐Vertex ☐Transverse/Oblique ☐ Constantly changing
If Breech, have you had an External Cephalic Version? Date and Doctor _____
Was the ECV successful? _____Have you tried other techniques?_____

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 ☐ Difficulty breastfeeding
☐ 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 ☐ Mild cramps ☐ Severe cramps ☐ Endometriosis ☐ Low back pain

Have you had any challenges with Fertility? Please explain _____