

Pregnancy Application for Care

Name: _____

Did a particular health problem prompt you to visit us? Y N

If so, please explain: _____

Previous Surgeries/Major Illnesses:

1. _____ 2. _____ 3. _____

Do you smoke? Y N Allergies: _____

Current Medications/Medications Taken Since Conception: _____

Had you been taking birth control? Y N Which type? _____

What types of exercises do you do currently? _____

Date of your last menstrual cycle: _____ Expected Due Date: _____

Are your cycles regular? Always ___ Most of the time ___ Never ___

Date of last x-rays, if any: _____ For what reason? _____

Have you had any previous pregnancies? Y N

Of those, were any cesareans? Y N How many? _____

Have you had a previous D&C procedure? Y N Please list the date(s): _____

Did you have any health complications during previous pregnancies? If so, please explain:

Where do you plan to have your baby? _____

Do you have any of the following?

Diabetes ___ Rh-Negative Blood ___ Asthma ___

Have you received chiropractic care previously? Y N If so, by whom? _____

Additional Comments: _____
