Culture
CHIROPRACTIC

Pregnancy Questionnaire

Name: _____ Date: _____

1. Is this your first pregnancy (circle one)? YES / NO
    a. If not, how many? _____
2. Have you experienced any miscarriages (circle one)? YES / NO
    a. If yes, how many? _____
3. How many weeks gestation? _____
    a. What day of the week does it change? _____
    b. What is your estimated delivery date? _____
4. Name of Obstetrician/Midwife: _____
5. Planned location of birth (circle one):
    a. Hospital: _____
    b. Birthing Center: _____
    c. Home
6. Have you had any ultrasounds (circle one)? YES / NO
    a. If yes, how many? _____
7. Any known complications at this time (circle one): YES / NO
    a. If yes, please explain: _____
8. Is there anything else that your doctor should know about your pregnancy or pregnancy history? _____