RADIUS CHIROPRACTIC PREGNANCY QUESTIONNAIRE

PATIENT DEMOGRAPHICS

PMID: _____

Practic Member Name: _____
Today's Date: _____/_____/_____

PREVIOUS BIRTH EXPERIENCE

Is this your first pregnancy? ☐ Yes ☐No

If not, please tell us about your previous births (how many, labor time, delivery method & interventions used, type of birth support, etc.)
_____
_____
_____
_____
_____

What if anything would you want to change about your previous birth experience? (if applicable)
_____
_____

Any postpartum complications or long term consequences after previous births? ☐ Yes ☐ No
If yes, please explain: _____

CURRENT HEALTH STATUS

When is your expected or calculated due date? _____/_____/_____ How far along are you? _____

Did you have any difficulty conceiving? ☐ Yes ☐ No
If yes, please explain: _____

Have you experienced morning sickness? ☐ Yes ☐ No
If yes, please explain: _____

Have you been experiencing any discomfort throughout this pregnancy? ☐ Yes ☐ No
If yes, please explain: _____

Are you currently exercising or stretching? ☐ Yes ☐ No
If yes, please explain: _____

Please tell us about your current diet, and any dietary restrictions:
_____
_____

Have you taken any medications or supplements during your pregnancy? ☐ Yes ☐ No
If yes, please explain: _____

Have you had any falls, motor vehicle accidents, or any other physical trauma during your pregnancy? ☐ Yes ☐ No
If yes, please explain: _____

Have you had any major emotional stressors during your pregnancy? ☐ Yes ☐ No
If yes, please explain: _____

How has your pregnancy been so far? Is it what you expected?
_____
_____

YOUR BIRTH PREFERENCES

What are your top 3 goals for this pregnancy?

1. _____
2. _____
3. _____

Are you taking any prenatal or birthing education classes? ☐ Yes ☐ No
If yes, which one(s)? _____

Who is your OBGYN or midwife? _____ Will they be present for delivery ☐ Yes ☐ No

Do you intend to have a birth coach or doula present for your birth? ☐ Yes ☐ No
If yes, who will be present? _____

Where do you plan to birth? ☐ Home ☐ Birthing Center ☐ Hospital
☐ Other: _____

If not at home, what is the name of the facility you will be birthing at? _____

What kind of birth are you planning for?

☐ Natural vaginal delivery with no intervention ☐ Natural vaginal delivery with pain medications
☐ C-Section due to medical reasons ☐ Elected C-Section ☐Vaginal birth after a C-Section (VBAC)

Do you plan on breastfeeding your child? ☐ Yes ☐ No

Do you have any concerns about this pregnancy, birth, or your birth plan?
_____
_____
_____

How can we best support you throughout this journey and do you have any specific questions for us today?
_____
_____
_____

_____ _____ / _____ / _____
Patient or Authorized Person's Signature **Date**