PREGNANCY
WELLNESS PROFILE

E 320 CHIROPRACTIC

NAME: _____ **DATE:** _____

DUE DATE: _____ **NUMBER OF WEEKS PREGNANT:** _____

REASON FOR VISIT:

☐ Wellness ☐ Low Back Pain ☐ Pubic Symphysis Pain
☐ Pelvic/Hip Pain ☐ Sciatica ☐ Headaches/Neck Pain
☐ Current Practice Member ☐ Other: _____

Congratulations on your pregnancy! It is important that we know your **PAST** history and your current **GOALS**, so please give us some information that will help us to serve you with excellence.

CURRENT PREGNANCY

HAVE YOU EXPERIENCED:

☐Use of fertility drugs/IVF ☐Morning Sickness ☐Pre- Eclampsia
☐Gestational Diabetes ☐High Blood Pressure ☐Anemia
☐Indigestion ☐Trauma/Accident ☐Ankle Swelling
☐Abnormal Bleeding ☐Thyroid Problems ☐Other: _____

DID YOU RECEIVE A FLU SHOT? ☐ No ☐Yes→ Date: _____

DID YOU RECEIVE ANY VACCINATIONS SINCE BECOMING PREGNANT? ☐ No ☐Yes→ Which one(s): _____

HOW MANY ULTRASOUNDS HAVE YOU RECEIVED? _____ **OTHERS PLANNED:** ☐ No ☐Yes

WILL YOU BE TAKING A BIRTHING CLASS? (DID YOU TAKE):

☐Bradley ☐ Lamaze ☐ Hypnobabies/Hypnobirthing ☐ Baby Steps
☐ Hospital Class ☐ Not sure yet ☐ None ☐ Other: _____

WHERE DO YOU PLAN TO GIVE BIRTH?

☐ Home ☐ Birthing Center→_____ ☐ Hospital→ _____

DO YOU PLAN TO USE: ☐Obstetrician ☐Mid-Wife

DO YOU PLAN TO USE A DOULA: ☐ No ☐Yes → Name _____

ARE YOU TAKING ANY SUPPLEMENTS AND/OR VITAMINS? ☐ No ☐Yes → _____

WHAT ARE YOUR HOPES OR EXPECTATIONS FOR THE BIRTH?

☐Natural birth ☐Epidural only if necessary ☐Definite Epidural ☐VBAC
☐Planned C- Section ☐Unsure ☐Other: _____

WHAT ARE YOUR BIGGEST WORRIES/CONCERNS GOING INTO THIS BIRTH? _____

PLEASE SELECT TOPIC(S) THAT YOU WOULD LIKE TO HEAR MORE ABOUT:

☐Doulas ☐Creating a Birth Plan ☐Chiropractic Care for Infants ☐Breast Feeding
☐Home Birth ☐Birthing Classes ☐Circumcision Decisions ☐Vaccination Decisions
☐Other: _____

PREGNANCY HISTORY

E 320 CHIROPRACTIC

NUMBER OF PREGNANCIES: _____ Vaginal _____ C-Section _____ Miscarriages

NAME & AGES OF CHILDREN:

1. _____
2. _____
3. _____
4. _____

PLACE OF BIRTH(S): ☐ Hospital ☐Birthing Center ☐Home ☐Other

DELIVERING PRACTIONER(S):

☐OB/GYN ☐Nurse Midwife ☐Certified Practicing Midwife ☐Lay Midwife

POSITION OF DELIVERY:

☐Lithotomy Position (On back with feet up) ☐On your Side ☐Kneeling ☐Squatting

☐Birthing Chair ☐Birthing Tub ☐Caesarian Section ☐Other_____

WAS LABOR MEDICALLY INDUCED: ☐No ☐Yes

If yes, were contractions simulated prior to the natural onset of labor? ☐No ☐Yes ☐Unknown

If yes, were contractions simulated after the labor had started? ☐No ☐Yes ☐Unknown

If yes, specify what type: ☐IV Pitocin ☐Prostaglandin Gel ☐Unknown ☐Other: _____

WERE YOUR MEMBRANES STRIPPED OR RUPTURED? ☐No ☐Yes ☐Unknown

DID YOU UTILIZE ANY PAIN MEDICATION OR ANESTHESIA? ☐No ☐Yes ☐Unknown

DID YOU EXPEREINCE ANY BACK PAIN DURING LABOR? ☐No ☐Yes ☐Unknown

BABY PRESENTATION AT TIME OF DELIVERY:

☐Normal ☐Posterior ☐ Brow ☐Facial ☐Breech

IF BREECH, specify type: ☐Footling ☐Frank ☐ Complete ☐ Kneeling

DID YOUR CARE PROVIDER ASSIST THE DELIVERY WITH HIS/HER HANDS? ☐No ☐Yes ☐Unknown

WERE OPERATIVE DEVICES USED TO FACILITATE THE BIRTH? ☐No ☐Yes ☐Unknown

If yes, which type? ☐Forceps ☐Vacuum ☐Extraction ☐Other_____

WAS THERE A BIRTHING COACH PRESENT?

☐Spouse ☐Doula ☐Friend ☐Other_____

AT WHAT WEEK OF PREGNANCY WAS THE BABY BORN? _____

DID YOU HAVE ANY COMPLICATIONS DURING ANY OF YOUR PREVIOUS PREGNANCIES?

☐No ☐Yes→ Explain: _____

HOW LONG WAS YOUR PREVIOUS LABOR?

Total Time: _____ Time before you pushed: _____ Time you spent pushing: _____

DID YOU HAVE CHIROPRACTIC CARE DURING YOUR PREVIOUS PREGNANCIES? ☐No ☐ Yes

AFTER 32ND WEEKS OF PREGNANCY

POSITION OF BABY: ☐Head down ☐Posterior ☐Breech or Malposition

CONFIRMED BY:

Palpation By: _____ Date: _____

Ultrasound By: _____ Date: _____

How long do you believe baby has been in this position? _____

NAME OF OB/MIDWIFE: _____

PRACTICE NAME: _____ **PHONE #:** _____

May we have permission to contact your birthing attendant and doula to confer with them and share information regarding the chiropractic care that you are receiving here?

☐No ☐Yes

WEBSTER TECHNIQUE

The Webster Technique as defined by the International Chiropractic Pediatric Association (ICPA):

The Webster technique is a specific chiropractic analysis and adjustment that reduces interference to the nervous system, balances out pelvic muscles and ligaments which in turn removes torsion to the uterus, reducing the potential for intra-uterine constraint and allows the baby to get into the best possible position for birth.

PATIENT SIGNATURE: _____ **DATE:** _____