CLIENT HISTORY INFORMATION RELATED TO PREGNANCY

Name of Client: _____

Phone #: _____

Email: _____

How did you hear about this clinic? _____

1. Do you see a:

   Obstetrician / Name and Contact info: _____

   _____

   Frequency of visits: _____

   Family M.D. / Name and Contact info: _____

   _____

   Frequency of visits: _____

   Midwife / Name and Contact info:_____

   _____

   Frequency of visits: _____

2. # of weeks pregnant (gestational age) _____ Due Date _____
3. Are you planning a:

   Home Birth _____ Hospital Birth (Facility) _____
4. Do you have any other children?_____
5. Do you have any issues related to pregnancy?_____
6. Any muscle issues related to pregnancy? _____
7. Any circulatory issues: swelling, numbness, tingling, blood pressure?
8. Location:_____
9. Any breast pain or tenderness?_____
10. What is your current blood pressure?_____
11. Are you seeing any other health care providers / complementary practitioners during your pregnancy? ie: Chiroprator, Acupuncture, Naturopath, etc?

    _____
12. Are you exercising during your pregnancy? If so, what are you doing?

    _____

    _____