Perinatal Health History Form

Pregnancy is a special time. We feel passionate about supporting mom-to-be during this exciting time. Many of the common aches and pains of pregnancy can be prevented when the body is adequately supported. Labour has also been shown to be shorter in women who received chiropractic care throughout their pregnancy. You are in the right place. We have training in the care of moms and babies. We are trained and certified in the Webster technique. Supporting and improving mom's body mechanics and internal health function gives your baby the best opportunity to be in the ideal position for a healthy birth. Minimizing in-utero constraint is also the best way of ensuring an ideal environment for baby to develop. We love caring for families and are happy you are here!

Please take a moment to answer these questions pertaining to your fertility history, pregnancy and, if applicable, post-natal period.

Current Pregnancy

Number of weeks pregnant: _____ Estimated Due Date: _____

Challenges during pregnancy (blood pressure, baby position, sensitivities, etc):

_____

_____

Desired location for delivery: □ Home □ Hospital □ Birth centre

Any other concerns or feelings you would like to share? _____

_____

Fertility History

Number of pregnancies: _____ □ Miscarriages (if applicable # weeks): _____

Any challenges conceiving? _____

Any assisted reproduction attempts/successes? _____

Past Pregnancies

1st: Length of pregnancy: □ Full Term □ Early (wks) _____ □ Late (wks) _____

2nd: Length of pregnancy: □ Full Term □ Early (wks) _____ □ Late (wks) _____

Challenges during pregnancy (blood pressure, baby position, sensitivities, etc):

_____

_____

Location of birth: □ Home □ Hospital □ Birth centre

Type of birth/delivery: □ Normal Vaginal □ Breech □ Caesarean

Invasive procedures: □ Epidural □ Forceps □ Vacuum

Length of labour: _____ Name of MD/OB/Midwife: _____

Post Natal Period

Any post natal challenges with current and/or previous pregnancies? (delayed healing, pelvic floor damage, incontinence, etc) _____

_____

Infant History:

□ Breast fed Latching well: □ Yes □ No Breast preference: □ Yes (□ L □ R) □ No

□ Bottle □ Formula – type and age introduced _____

# of hours sleep each night _____ Number of hours sleep in a row _____

Infant quality of sleep: □ Good □ Fair □ Poor

Is there any additional information that may help us understand your health, family and life balance? _____

_____

_____