WOMEN'S HEALTH QUESTIONNAIRE

CLEVELAND CHIROPRACTIC ASSOCIATES, INC.

Name: _____ Date: _____

Purpose of this appointment and list your complaints:_____

_____

_____

1) If you are currently pregnant, how many months are you pregnant and what is the Expected Date of Delivery of the baby? _____

2) If this your first pregnancy? _____

3) If this is not your first pregnancy, how many previous births have you had? Please list your children's names and ages. Were any of your children VBAC, C-section, Breech or traumatic (long labor and delivery) births?

_____

4) Have you had any traumas (car accidents, slips, falls) prior to or during this pregnancy? If yes, please describe. _____

_____

5) Do you have low back pain? _____

6) Do you have Sciatica nerve pain (pain that travels down your thigh, leg or foot)? _____

_____

7) Do you have pubic joint pain (front of pelvis)? _____

8) Do you have nausea or vomiting or morning sickness? _____

9) Are you very exhausted or fatigued all the time? _____

10) Do you have headaches? _____

11) Do you have a baby that is breech or posterior in position? _____

12) Have you been seen by your OBGYN provider (doctor, midwife)? If yes, what is his or her name?

_____

13) Have your pregnancy blood tests, sugar tests and blood pressure been normal? If no, please explain? _____

14) Have you had an ultrasound of the baby? If yes, how many? _____

15) Are you taking any medication? Please list them._____

16) Are you taking any supplements, herbs? Please list them. _____

17) Have you been eating healthy during the pregnancy? _____

18) How much weight have you gained during your pregnancy? _____

19) Are you exercising during this pregnancy? If yes, what activities are you doing?

_____

20) Have there been any stressful events (moving, new job, new house, loss of family member, etc.) during this pregnancy? _____

21) Are you currently using the services of a Doula? If so, whom?_____

22) Are you planning a hospital birth or a home birth? _____

23) Do you plan to nurse your newborn? _____

24) Do you plan to vaccinate your newborn? _____

25) Have you ever had any problems with infertility or getting pregnant? _____

26) Have you ever had Endometriosis, Pelvic Inflammatory Disease or Polycystic Ovarian Disease?

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