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PRENATAL CHIROPRACTIC INTAKE FORM

PATIENT DATA

NAME: _____ DATE: ___/___/____

Date of birth: ___/___/___

CURRENT PREGNANCY

Due Date/Week: _____ I am in my ____ week of pregnancy.
Pre-pregnancy Weight: _____ Current Weight: _____ Height: _____
Childbirth Preparation: Bradley ___ Lamaze ___ Other _____
Childbirth Caregiver(s): OB/GYN: __ Doula __ Midwife__
Caregiver's name and phone number: _____
I plan on giving birth at: Hospital __ Birth Center __ Other _____
Name of Hospital or Birth Center: _____
What position do you sleep in: Side __ Back __ Stomach __
How many hours of sleep are you getting each night on average? _____
How would you rate your overall stress level (circle one)?
No stress 1 2 3 4 5 6 7 8 9 10 Very stressed
Do you drink ½ of your body weight in ounces of water per day (circle one)? Yes No
Are you eating a clean, well-balanced diet (circle one)? Yes No
Are you exercising during your pregnancy (circle one)? Yes No
If yes, what type of exercise? _____
Any traumas during this pregnancy (circle one)? Yes No
If yes, please explain: _____
Any hospitalizations during this pregnancy (circle one)? Yes No
If yes, please explain: _____
Any medications during this pregnancy, including over-the-counter?
_____
What supplements are you currently taking? _____
Any fertility treatment(s)? _____
Have you had any chiropractic care during this pregnancy? Please explain
_____
Any additional information you would like us to know about your pregnancy?
_____

AFTER 32ND WEEK OF PREGNANCY

Position of baby: Head down _____ Posterior _____ Breech or malpositioned _____
Confirmed by: Palpation by: _____ on ___/___/___
Ultrasound by: _____ on ___/___/___
How long do you believe the baby has been in this position? _____

PREVIOUS PREGNANCIES

Number of previous pregnancies:_____ Number of births: _____
Please explain any difference in numbers: _____
Names and ages of children: _____
Your previous births were at: Hospital? _____ Home? _____ Birth center? _____
Medications used in prior births: None/natural _____ Pitocin _____ Epidural _____
Interventions used in prior births:
Induced labor/breaking water _____ Vacuum _____ Extraction _____ Forceps _____
Episiotomy _____ Caesarean section _____ Other: _____
How long was your previous labor?
Total: _____ Time before you pushed: _____ Amount of time spent pushing: _____
Did you receive chiropractic care during your previous pregnancy(s) (circle one)? Yes No
Any additional information you would like us to know about your previous pregnancy(s)? _____
_____

WEBSTER TECHNIQUE AGREEMENT

- I acknowledge that the Webster Technique is a specific chiropractic analysis and diversified adjustment. The goal of the adjustment is to reduce the effects of sacral/pelvic subluxation and/or SI joint dysfunction. In doing so neuro-biomechanical function in the pelvis is improved.
- I acknowledge that in a theoretical and clinical framework of the Webster Technique in the care of pregnant women, sacral subluxation may contribute to difficult labor for the mother (i.e. dystocia). Difficult labor is caused by inadequate uterine function, pelvic contraction, and baby mal-presentation. The correction of sacral subluxation may have a positive effect on the causes of difficult labor.
- I acknowledge that sacral misalignment may contribute to these primary causes of difficult labor via uterine nerve interference, pelvic misalignment and the tightening of specific pelvic muscles and ligaments. The resulting tense muscles and ligaments and their abnormal effect on the uterus may prevent the baby from comfortably assuming the best possible position for birth.
- I understand that this sacral/pelvic analysis and adjustment may be used on all weight bearing spines: male, female, pregnant or not pregnant.
- I acknowledge that this is not a breech turning or in utero-constraint technique.

By signing this form, I understand the purpose of the Webster Technique and I agree to have the doctor perform the technique on me at her discretion. By signing this form, I also verify that all of my information is correct and that I have completed all questions with as much information as possible.

Patient Signature:_____ Date: _____