BODY ELEMENTS CHIROPRACTIC AT ENCORE
believe in better! believe you deserve it!
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Obstetrics History

Name: DOB: Today's Date:

Your purpose today for visiting this office today is:
☐ Temporary pain reduction ☐Corrective care ☐Wellness care ☐Manual Chiropractic adjustments
☐Bio Energetic Synchronization (B.E.S.T.) ☐Nutrition Response Therapy (NRT) ☐KST
☐ArthroStim ☐Activator ☐Other:

How far along are you? weeks	Estimated due date?
Any concerns about the pregnancy?	
Is this your first pregnancy? ☐ Yes ☐ No	If no, how many other child births have you had?
	Methods of birth?
	Any complications?
Are you working with any practitioners to help with your pregnancy and birth?	
What type of care have you received so far?	
Person(s) to help support you during pregnancy and birth?	
Are you taking any classes?	
How do you feel about being pregnant?	
Do you have any concerns about giving birth?	
Do you have a birth plan?	Where do you plan on giving birth?
Are you open to using medical intervention?	
Have you been diagnosed with high blood pressure?	
Is your urine being monitored for protein?	

Do you experience any of the following?

☐ Nausea	☐ Cramping
☐ Diarrhea Heart attacks	☐ Contractions
☐ Fever Angina / chest pain	☐ Bladder
☐ Painful urination Pacemaker	☐ Bowel dysfunction
☐ Bleeding Stroke	☐ Brest tenderness
☐ Discharge	☐ Abdominal pain

Signature and name: _____ Date: _____

Your health is your greatest asset. Thank you for the opportunity to serve you!