River City CHIROPRACTIC

# Prenatal Healthcare Form

4311 W 6th Street, Ste C
Lawrence, KS 66049
785-856-0423

## PERSONAL DATA:

Today's Date _____
Name (first middle last) _____ Date of Birth _____
Address, phone numbers, email, employment info, or emergency contact changed from initial intake form? ❑ Yes ❑ No

## Birth Plan Support:

Birth Care Provider: ❑ OBGYN ❑ Certified Nurse Midwife ❑ Certified Practicing Midwife ❑ Lay Midwife
Name & Office _____ Phone _____
Name & Office _____ Phone _____
Please list all involved supporters (birth coaches, including doulas) that you plan to have at the birth
Name _____ Relation _____ Phone _____
Name _____ Relation _____ Phone _____
Name _____ Relation _____ Phone _____

## Prenatal History:

Have you been pregnant before? ❑ Yes ❑ No If yes, # of births? _____ # of Miscarriages: _____
Dates of Births: _____
At what week of pregnancy was each child born? _____
**Please mark all that apply to previous deliveries:**
Delivering Practitioner: ❑ OBGYN ❑ Certified Nurse Midwife ❑ Certified Practicing Midwife ❑ Lay Midwife ❑ Doula
Place of Birth: ❑ Hospital ❑ Home ❑ Birthing Center ❑ Other
Delivery Position: ❑ Supine (on back, feet up) ❑ Side-lying ❑ Kneeling ❑ Hands/Knees (all fours) ❑ Squatting
Was Labor Induced (contractions stimulated *PRIOR* to the natural onset of labor)? ❑ Yes ❑ No ❑ Unknown
If yes, specify type: ❑ Pitocin ❑ Prostaglandin Gel (applied to cervix) ❑ Unknown
Were contractions stimulated intravenously (IV) with Pitocin *ONCE* labor started? ❑ Yes ❑ No ❑ Unknown
Were your membranes artificially ruptured by your care provider (to break your water)? ❑ Yes ❑ No ❑ Unknown
Did you receive pain medications or anesthesia? ❑ Yes ❑ No ❑ Unknown
If yes, specify type used _____
Back pain during labor? ❑ Yes ❑ No ❑ Unknown
Baby presentation at time of delivery: ❑ Normal ❑ Posterior ❑ Brow ❑ Facial ❑ Breech ❑ Unknown
If Breech, specify type: ❑ Footling ❑ Frank ❑ Kneeling ❑ Complete
Delivery: ❑ Vaginal ❑ Caesarian Section ❑ Delivered with hands ❑ Turning of the baby's neck or traction (pulling)
❑ Forceps ❑ Vacuum Extraction
Birthing Coach Present: ❑ Spouse ❑ Doula ❑ Friend ❑ Other _____

## Current Pregnancy:

Weeks Pregnant _____ Due Date _____
Delivery Location? ❑ Hospital ❑ Home ❑ Birthing Center ❑ Other_____
**Please mark all that apply to this pregnancy**:
❑ Falls ❑ Accidents ❑ Traumas ❑ Medications ❑ Vaccines ❑ Smoke or Tobacco Use ❑ Alcohol
❑ Recreational Drugs ❑ Ultrasounds ❑ Amniocentesis ❑ Stress ❑ Prenatal Vitamins ❑ Diet Change
Please explain any of the above: _____
_____
_____
_____

*I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize RCC to provide me with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance to Kansas' statutes.*

Patient or Guardian Signature _____ Date _____

Treating Doctor Signature _____ Date _____

***Thank you for choosing River City Chiropractic. We look forward to helping you.***