

**The Prana Group**  
**Supplemental Intake Form For Pregnancy & Post Partum**

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**General Information**

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Approximate week of pregnancy: \_\_\_\_\_ **OR** Date of birth: \_\_\_\_\_  
Approximate due date: \_\_\_\_\_

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History/Pattern during routing hormone cycle prior to pregnancy (please include information pertaining to PMS etc.):

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History of contraceptives (what form, for what length of time and did you ever have difficulty adjusting to the altered chemistry or hormonal levels?): \_\_\_\_\_

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History of previous pregnancies?     Yes     No

If so, how many and what dates? \_\_\_\_\_

If so, please provide details of the previous miscarriage(s), the pregnancy(s), the birth and your experiences postpartum.

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Have you received chiropractic care in the past for a previous pregnancy?     Yes     No

If Yes, for what reason and how would you describe your experience? \_\_\_\_\_

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**Birthing Care Team**

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Please identify the members of your team:

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|---|--|
| <input type="checkbox"/> Midwife              | <input type="checkbox"/> Chiropractor      |
| <input type="checkbox"/> Medical Doctor/OBGYN | <input type="checkbox"/> Doula             |
| <input type="checkbox"/> Pediatrician         | <input type="checkbox"/> Massage Therapist |
| <input type="checkbox"/> Other: _____         |  |

Names of the above mentioned: \_\_\_\_\_

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**Review of Current or most Recent Pregnancy**

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Please include details of your experience(s) to date, any information regarding any investigation or evaluation tests that have been performed and the results or conclusions made. When discussing pre-natal care be sure to include frequency of visits and level of invasiveness at each visit.

**First trimester:**

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**Second trimester:**

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**Third trimester:**

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**Pre-natal testing:**

Please include the date the testing was/or is to be performed.

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|--|--|
| <input type="checkbox"/> Ultrasound _____      | <input type="checkbox"/> Amniocentesis _____     |
| <input type="checkbox"/> CV Sampling _____     | <input type="checkbox"/> Alfa-feto protein _____ |
| <input type="checkbox"/> Non stress test _____ | <input type="checkbox"/> Blood Work up _____     |
| <input type="checkbox"/> Other tests: _____    |  |

Pre-natal classes, activities and exercise programs that are/have been currently being pursued.

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**Labour, Delivery & Postpartum:**

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