

**CONTEMPLATIVE BIRTHING WORKSHOP
PREGNANCY/HEALTH HISTORY FORM**



Name: _____ Date: _____

Due Date: _____ Pregnancy #: _____

Contemplative Birthing Workshop Start Date: _____

It is my intent to provide you with a safe and supportive class experience. There are some conditions I need to be aware of in order to modify our classes and lectures in the best interest of you and your baby. Please ask your maternity healthcare provider if he or she has any concerns about you participating in any type of physical activity. If there are specific precautions, please contact me about them either by phone or email at 401-338-5466 or kaeli@motioncenter.com. You are also welcome to have your healthcare provider contact me directly.

Please complete the following questionnaire:

High Risk Factors: (please check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Pre-pregnancy diabetes | <input type="checkbox"/> Genetic disorder/DES/uterine abnormalities |
| <input type="checkbox"/> Cardiac disorders (heart or pulmonary problems) | <input type="checkbox"/> Multiples (twins, triplets, etc.) |
| <input type="checkbox"/> Hypertension/high blood pressure | <input type="checkbox"/> Mother's age under 20 or over 35 |
| <input type="checkbox"/> Thyroid disorder | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> RH negative | <input type="checkbox"/> Drug/Alcohol use |
| <input type="checkbox"/> Previous complications of pregnancy (this or prior) | <input type="checkbox"/> Renal/liver/blood/convulsive disorders |

Pregnancy Complications: (please check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Gestational diabetes | <input type="checkbox"/> Fetal development complications |
| <input type="checkbox"/> Threatened miscarriage | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Early labor | <input type="checkbox"/> Pregnancy-induced hypertensive disorders
(preeclampsia/eclampsia/toxemia) |
| <input type="checkbox"/> Placental dysfunction | <input type="checkbox"/> Kidney/liver and/or bladder disorders |
| <input type="checkbox"/> Cesarean birth (other child or planned) | |

Non-pregnancy related complications: (please check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Cancer or undiagnosed lumps | <input type="checkbox"/> Heart Conditions: _____ |
| <input type="checkbox"/> Infection | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Autoimmune disorder | <input type="checkbox"/> Thrombophlebitis |
| <input type="checkbox"/> Musculoskeletal Injury | <input type="checkbox"/> Skin irritation and/or discharge |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Fracture, bleeding, burns or other
acute injury (circle) |