Your Pregnancy Health Story

ABDOMINAL THERAPY COLLECTIVE

Please fill out this questionnaire to the best of your ability. Answer only those questions with which you are comfortable.

The goal of this Health Story is to look at you and your life experiences holistically, compassionately and as a tool for education.

Name

Address

Due date

Phone

Email

Date of birth

Would you care to share your pronouns?

How did you hear about me and this work?

Abdominal Therapy is not a substitute for care by your medical doctor. Abdominal Therapy practitioners do not diagnose. Abdominal Therapy practitioners do not prescribe medical pharmaceuticals.

I have stated all known conditions and will keep my practitioner updated on my health. By signing below, I confirm all the information I've provided is correct. I understand this information will remain confidential.

Signature

Name Date

What's the reason for your visit?

Primary reason for this visit?

What would you like to achieve as a result of your visit?

When did you first notice this?

What makes you feel better?

What makes you feel worse?

COVID-19 Information

Have you had Covid-19?	Yes	No
If so, when?		
Are you vaccinated against Covid-19?	Yes	No
Do you have any symptoms in connection with the vaccination or the infection?	Yes	No
If yes, can you describe these?		

A Little bit of History

Are you taking any of the following – medication, supplementation, natural remedies?
If so, please give details:

Are you allergic to anything? If so, what reaction do you have?

Have you experienced any of the following? If so, please share some details.

Surgery

Accidents

Injuries to sacrum/head/tailbone

Family Story

What is your birth story?

Do you know about your birth parent's experience of pregnancy, birth, and early parenting?

Do you have siblings who have given birth?

What family or community support do you have for this pregnancy and postpartum?

Gut Health

Describe your relationship with food during this pregnancy?

Do you have any food sensitivities, intolerances or allergies?

Do you follow a particular diet?

Do you eat home cooked food?	Mainly	Occasionally	Never

What is your typical daily intake of the following?

Water	Caffeine	Alcohol
Protein	Fruit	Veg

How often are your bowel movements?

Do you suffer from abdominal pain, constipation, diarrhea, incomplete bowel movements, thin stools, blood, or mucus in your stools?

Mental & Emotional Health

How do you nurture yourself?

Where and how do you find joy?

Are you currently experiencing stress?

Do you have a faith or spiritual practice and if so, would you be willing to share this?

What exercise do you enjoy, and how often do you do it?

Do you experience low mood, anxiety, depression, post-traumatic stress disorder, or anything else you would like to share?

Have you experienced any traumatic events that you would be willing to share?

How do you feel about giving birth?

Have you considered seeking professional support relating to any of the above?	Yes	No

Pregnancy Health

How was conception for you? Easy? Unexpected? Assisted?

Who is your care provider and where do you plan to give birth?

Have any pregnancy risk factors been identified for you? Please specify if so.

Do you experience any of the following? If so, please indicate which apply to you:

Carpal tunnel syndrome	Itchy skin	Swelling	Hemorrhoids
Cramps	Incontinence	UTI	Sleep issues
	Nausea/Vomiting	Yeast infections	Irritability

Have you or your partner been pregnant before?	Yes	No

If so, did you choose to continue with these pregnancies and what were they like?

Have you experienced any loss?

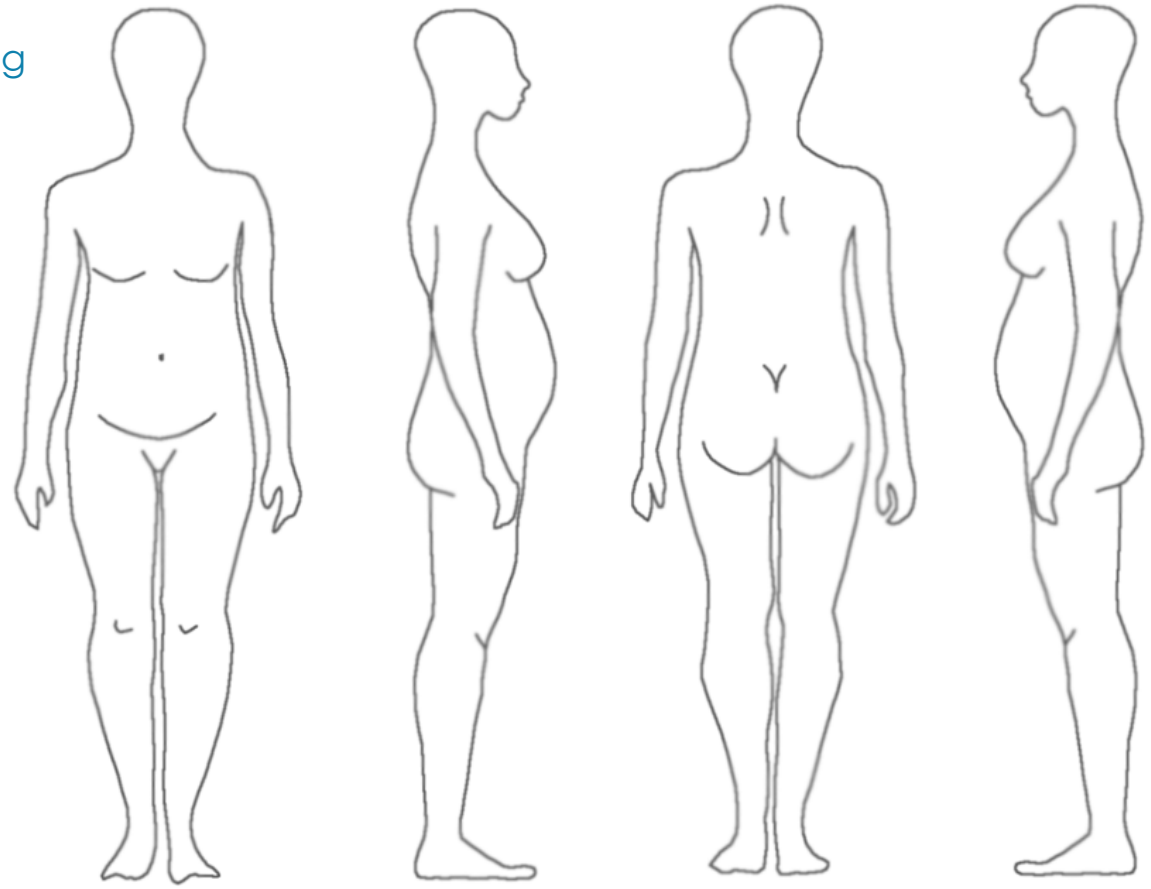
Have you or your partner given or witnessed birth? If so, what was your/their experience?

How many children are in your family and what are their ages?

Please describe your postpartum experience.

Are you experiencing pain or discomfort?

Please indicate location on these images:



Thank you for taking the time to share your information.

Is there anything else you would like to tell me?