

Chiropractic – Pregnancy

File No: _____

Date: _____

General Information

How do you wish to be addressed in our office?

First name Mr Mrs Miss Ms Dr

How do you wish to be contacted by our office? Email Phone

Name:

Last: _____ D.O.B. _____

First: _____

Address: _____

Town/City: _____ Province: _____ Postal Code: _____

Home Phone: () _____ Cell Phone: () _____

Email: _____ Expressed consent to receive email communication from the clinic

Please Initial

Occupation: _____ Spouse's name (if applicable): _____

Children: Y N Number: _____ Ages: _____

Are you pregnant? Y N How many weeks? _____

Family Dr. Name: _____ Phone: () _____

Previous Chiropractic Care? Y N If Yes, Doctor's name: _____

Referred by: _____

How did you decide to choose our office? _____

Reason for consulting the office:

- I have a specific problem and require help only with this problem.
- After my specific problem has been relieved, I am interested in strategies to insure the problem does not return.
- After my specific problem has been resolved and I understand methods to insure it does not return, I am interested in strategies to improve my general health.
- I have no symptoms and I feel well. I am interested in strategies to help me to continue to feel well, or even better.

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Health History

The following health history is designed to uncover all areas of ill health. As the human body is designed to be healthy, any deviation from optimal health will reduce your body's wellness potential. A detailed history can give your chiropractor valuable insight into the wellness condition of your body prior to your pregnancy. Your health history includes your journey from childhood to present. Please take the time to fully complete this form to the best of your ability:

A. Growth and Development

Y N To your knowledge, were there any difficulties or interventions employed at your own birth? (difficult delivery, forceps, vacuum extraction, epidural, c-section)

Explain: _____

Y N To your knowledge, did you ever experience a fall (out of bed, off a change table, table etc.) as an infant/toddler?

Explain: _____

Y N Childhood Illnesses? Name: _____

Y N Childhood Accidents? (include sports injuries, slips and falls, etc.)

Explain: _____

Y N Did you ever play contact sports?

Y N Have you ever been told you have a scoliosis?

Y N Any other childhood traumas?

Explain: _____

Y N Were you vaccinated as a child?

B. Current Health Status

Y N Have you had any past surgeries? If so, what?: _____

Y N Do you smoke?

Y N Have you smoked in the past? Date quit: _____

Y N Do you drink any alcohol? If so, how much/week? _____

Y N Do you feel that you have an adequate diet, especially vegetables?

Y N Have you ever been in a motor vehicle collision (include minor ones)?

Explain: _____

Y N Have you had any other accidents, trauma or fractures?

Explain: _____

Y N Previously diagnosed medical conditions? List: _____

Y N Does your job and/or daily activities require that you do a lot of twisting?

Y N Drugs / Prescription / Over the Counter / Recreational / Birth Control

If yes, list drug and condition: _____

Y N Dental problems?

Explain: _____

Y N Hearing problems?

Explain: _____

Y N Regular Exercise? Aerobic Non-Aerobic _____ x/week

Stress: Occupational _____ Physical _____ Mental _____

Sleeping Posture: Back _____ Front _____ Side _____

Hours of sleep per night on average: _____ / night

C. Health Symptoms

Health symptoms often appear after years of underlying dysfunction and/or in pregnancy. Please briefly describe any current painful symptoms you are experiencing:

How long ago did the problem start? _____

Did you have the problem prior to your pregnancy? Y N

The pain you experience is: CONSTANT OCCASIONAL

What aggravates your pain or problem? _____

What relieves your pain or problem? _____

Does your pain radiate or travel to other parts of your body? Y N

Does your condition get worse at certain times of the day or night? _____

How long does the pain last when you get the pain? _____

Is your condition getting: WORSE BETTER

Have you consulted other health professionals regarding this problem? Y N

If yes, which ones? _____

Have you taken any medications for this problem? Y N

If yes, what medication and for how long? _____

Family History of: Heart Disease Stroke Cancer Diabetes

Other: _____

D. Other Symptoms

Please place a check on the line if you currently experience or have experienced any of these in the past:

- | | | |
|---|---|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> Loss of taste |
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Stomach upset |
| <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Depression | <input type="checkbox"/> Abdominal pain |
| <input type="checkbox"/> Stress | <input type="checkbox"/> Memory loss | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Cold sweats |
| <input type="checkbox"/> Chest pains | <input type="checkbox"/> Ear infections | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Heart trouble | <input type="checkbox"/> Prostate problems |
| <input type="checkbox"/> Stiff neck | <input type="checkbox"/> Circulation problems | <input type="checkbox"/> Hepatitis B |
| <input type="checkbox"/> Pins & needles in legs | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Pins & needles in arms | <input type="checkbox"/> Fainting | <input type="checkbox"/> Trouble with bowel or bladder control |
| <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Reproductive problems (endometriosis, fibroids, impotence, etc.) |
| <input type="checkbox"/> Painful menstruation | <input type="checkbox"/> Stroke | |

Expectations:

Please list your top 3 expectations that you have regarding your care at Waterdown Village Chiropractic Group:

1. _____
2. _____
3. _____