Pregnancy
Wellness Profile

Patient Information

Name: _____ Nickname: _____
Birth Date: _____ Height: _____ Weight: _____
Home Address: _____ City_____ State____ Zip_____
Home Phone: _____ Cell Phone: _____
Email: _____ Preferred Contact Method: _____
Occupation: _____ Company: _____
Spouse's Name: _____ Phone Number: _____
Emergency Contact: _____ Phone Number: _____
Name(s) and Age(s) of Children: _____
How did you hear about us? _____
Payment: ☐Personal Insurance ☐Self Pay ☐Third Party Insurance Co.: _____
Are you the Policy Holder? ☐Yes ☐No Primary Name: _____ Primary DOB: _____
Do you have a secondary policy? ☐Yes ☐No Do you have a Health Savings Account? ☐Yes ☐No

Healthcare History

Have you had previous Chiropractic Care? ☐ Yes ☐ No
Doctor/Clinic: _____ Date of last adjustment: _____
Were X-rays taken in the last 6 months? ☐Yes ☐No Where? _____
What was the primary reason for consulting that office?
☐ Relief Care – Symptom relief of pain or discomfort
☐ Corrective Care – Correcting, relieving, and stabilizing spinal, joint, or postural issues
☐ Wellness Care – Maximizing the body's ability for optimal healing and function
Family Doctor: _____ Phone Number: _____
Date and reason of last visit: _____

Other Health Care Professional (Medical Specialist, Naturopath, Homeopath, Physiotherapist, Massage, etc.)

Name: _____ Clinic Name: _____ Phone Number: _____
Professional Designation: _____ Date and reason of last visit: _____

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Pregnancy Profile

How far along in your pregnancy are you? _____ When is your baby's due date? _____
Have you taken any medications during this pregnancy? ☐No ☐Yes
OTC and Reason: _____
Prescription and Reason: _____
Vaccines and Reason: _____
Have you experienced any physical trauma during this pregnancy? ☐ No ☐ Yes
If yes, please explain: _____
Have you had any evaluation procedures (ultrasound, amniocentesis, chorionic villus sampling)? ☐No ☐Yes
Dates and Reason:_____
Have there been any stressful events in your life during this pregnancy? ☐No ☐Yes
If yes, please explain: _____
What type of birth care provider(s) are you planning on using? ☐Doula ☐Midwife ☐OB/GYN ☐Other
Where do you plan on delivering your baby? _____
Is this your first pregnancy? ☐Yes ☐No
If not, how many pregnancies previously? _____
How many children do you have? _____
Miscarriages? ☐ No ☐ Yes ☐ D&C (dilation & curettage) ☐Natural Miscarriage
How many vaginal deliveries? _____ How many C-sections? _____
Have there been any complications during your previous deliveries? ☐No ☐Yes
If yes, please explain: _____
Was labor induced, or was Pitocin used? ☐ No ☐ Yes ☐ Unknown
Did your care provider rupture your membranes? ☐ No ☐Yes ☐ Unknown
Was there any back or hip pain during labor? ☐ No ☐ Yes
Was the baby in a sub-optimal position during the pushing phase of labor? ☐ No ☐Yes ☐ Unknown
Did you receive an epidural? ☐ No ☐ Yes
Were there any operative devices used? ☐ No ☐Forceps ☐ Vacuum ☐ Other _____
Were there any postpartum complications or long-term consequences? ☐ No ☐Yes
If yes, please explain: _____

Have you experienced any of the following symptoms during this pregnancy or a previous pregnancy?

CURRENT	PREVIOUS		CURRENT	PREVIOUS	
☐	☐	Headaches	☐	☐	Carpal Tunnel (numbness in hands / fingers)
☐	☐	Facial Paralysis	☐	☐	Low or Mid Back Pain
☐	☐	Chronic Fatigue	☐	☐	Breech or Side-lying Presentation
☐	☐	Nausea / Morning Sickness	☐	☐	Round Ligament Pain or Pulling (front of belly)
☐	☐	Heartburn / Indigestion	☐	☐	Pain in your Pubic Bone
☐	☐	Pre-eclampsia	☐	☐	Pins or Needles in the front or side of your leg
☐	☐	Gestational Diabetes	☐	☐	Pain in the Posterior Leg (Sciatica)
☐	☐	Constipation	☐	☐	Leg Cramps
☐	☐	Hemorrhoids	☐	☐	Swelling of Ankles, Legs, or Feet

Wellness Profile

Do you have a specific concern that brings you in?

☐ No, I want to have my spinal and pelvic alignment assessed to help the growth and delivery of my baby

☐ Yes: _____

If yes, please answer the following questions:

What is your primary area of complaint today? _____

How long have you been experiencing this complaint? _____

Where else does this pain go in your body? _____

How often do you experience this? _____

On a scale of 1 to 10 (10 being the worst), how high does the pain get? _____

How would you describe the pain or discomfort?

☐ Dull ☐ Achy ☐ Throbbing ☐ Stabbing ☐ Tight/Stiff ☐ Burning ☐ Sharp ☐ Other _____

What makes it feel worse? _____

What makes it feel better? _____

Do you notice any other problems in your body when you get this pain or discomfort? ☐ No ☐ Yes

If yes, please explain: _____

Do you feel your condition is getting better or worse? ☐ Better ☐ Worse ☐ Staying the same

What have you tried that **has** helped? ☐ Ice ☐ Heat ☐ Medication ☐ Massage ☐ Phys. Ther. ☐ Chiropractic

Other: _____

What have you tried that **hasn't** helped? ☐ Ice ☐ Heat ☐ Medication ☐ Massage ☐ Phys. Ther. ☐ Chiropractic

Other: _____

Lifestyle Information

The human body is designed to be healthy. The primary system in the body which coordinates health and function is the nervous system. Your nervous system is surrounded and protected by the bones of the spine, called vertebrae. Physical, emotional, and chemical stresses, common to our contemporary lifestyle, can result in misalignment to the spinal column as well as damage the delicate nervous system. The result is a condition called Vertebral Subluxation. The remainder of the intake form addresses the possible factors which may contribute to vertebral subluxation in your spine, which may be impeding your body's ability to heal.

Physical Information

Frequency of exercise per week: _____ Days of cardio: _____ Days of weights: _____

Do you stretch after exercise or similar activities? ☐ Yes ☐ Sometimes ☐ No

How many hours of sleep do you get at night? _____

Do you feel refreshed upon waking? ☐ Always ☐ Most Days ☐ Sometimes ☐ Rarely / Never

How old is your mattress? _____ Have you considered getting a new mattress? ☐ No ☐ Yes

Which position do you sleep in? ☐ Back ☐ Belly Side: ☐ Right ☐ Left

Number of hours spent in a car per week? _____

Number of hours spent at a desk or computer per week? _____

Number of hours spent on a phone or tablet per week? _____

Do you perform repetitive tasks at home or at work? ☐ No ☐ Yes

Have you ever been hospitalized or had surgery? ☐ No ☐ Yes

If yes, why and when? _____

Have you ever been in a motor vehicle accident (even if it was a minor accident)? ☐ No ☐ Yes

If yes, please explain: _____

Were you evaluated and treated after the accident(s)? ☐ No ☐ Yes

Have you had any other accidents or falls? ☐ No ☐ Yes _____

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name _____ Date _____
Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersigned does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State Law and Federal Law.

Name _____ Date _____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State Law:

By _____
Signature of Parent/Guardian (circle one)