CONFIDENTIAL CASE HISTORY

Please complete this questionnaire. Your answers will help us determine how our care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case but will work to refer you to the appropriate health care provider. If you need help with this form, please do not hesitate to ask us.

PERSONAL INFORMATION

Patient name: _____ Date: _____

Date of Birth: mm_____dd_____yr_____ Age: _____ Sex (circle): ●Male ●Female

Address (street, city, state, zip): _____

Current Weight: _____ Height: _____ Marital Status (circle): ●Married ●Single

Number of children: _____ Children's Names: _____

Phone (cell): _____ Phone (home): _____

Employer/occupation: _____ Phone (Business): _____

E-Mail: _____Nickname: _____

Emergency Contact Name, Relation, and Phone:

_____

How did you hear about us? _____

HEALTH INFORMATION

Names of health care professionals you are working with during your pregnancy and/or delivery?

_____

_____

Renew Chiropractic, PLLC
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What is your due date? _____ How many weeks along are you currently? _____

Is this your first pregnancy? ●Yes ●No

If no, please tell us about your previous pregnancy and/or birth experience(s) (Duration, interventions, etc.):

_____

_____

Do you plan to follow the same plan as your previous delivery? ●Yes ●No

If no, what would you like to change: _____

_____

Have you seen a chiropractor in the past (previous pregnancies or in general? ●Yes ●No

If yes, name and date: _____ Were X-rays taken? ●Yes ●No

Results: _____

Current medications or supplements and reason for use: _____

_____

List surgical operations and/or major injuries: _____

_____

Have you been in an auto accident? If yes, when? _____

Describe the accident: _____

Have you had any other personal injury or accidents? If yes, when? _____

Describe: _____

Date of most recent physical examination: _____

Family History:

□ Anemia	□ Diabetes	□ High Blood Pressure	□ Prostate Problems
□ Arthritis	□ Exzema	□ Hypoglycemia	□ Psoriasis
□ Cancer	□ Emphysema	□ Lumbago	□ Rheumatoid Arthritis
□ Chronic Neck Pain	□ Epilepsy	□ Migraine Headaches	□ Scoliosis
□Chronic Back Pain	□ Heart Problems	□ Multiple Sclerosis	□ Spine Surgery

PRESENT COMPLAINT

Reason for visit: _____

_____

Does this concern affect (circle all that apply):

●sleep ●daily routine ●work ●other activities ●does not affect

Please explain: _____

Have you had any past treatment for this complaint? ●Yes ●No

If yes, please explain: _____

When did the present complaint begin? _____

_____

It began… (circle the appropriate answer): ●Suddenly ●Gradually ●Post-injury

If injury-related, please explain: _____

The condition is getting (circle all that apply):

●worse ●improving ●intermittent ●constant ●not sure

What makes the problem better? _____

What makes the problem worse? _____

Have you ever had a similar condition? ●Yes ●No

If yes, please explain: _____

_____

Anything else you would like us to know about this concern? _____

_____

_____

Any other health concerns: _____

_____

YOUR HEALTH GOALS

What are your top 3 goals for this pregnancy?

1. _____

2. _____

3. _____

Do you currently have a birth plan? ● Yes ● No

If yes, please explain: _____

_____

Are you taking any pre-natal or birthing classes? ● Yes ● No

Do you intend to have a doula or birth coach present? ●Yes ● No

Do you wish to have a natural vaginal labor and delivery? ●Yes ● N0

Is there anything else you would like to tell us about your pregnancy or birth plan? _____

_____

What would you like to gain from chiropractic care during your pregnancy? _____

_____

DO YOU KNOW ABOUT CHIROPRACTIC?

Do you know what a subluxation is? ●Yes ●No

Were you aware that chiropractic is the largest natural healing profession in the world? ●Yes ●No

Did you know that Doctors of Chiropractic work with the nervous system? ●Yes ●No

Did you know that the nervous system controls all bodily functions and systems? ●Yes ●No

I, the undersigned, having been explained the risks of treatment, do hereby request and consent to the performance of chiropractic treatment and related physical therapy procedures upon the above- named patient (my dependent or myself). I wish to rely on the chiropractor to exercise judgement for my best interest during the course of treatment. I will inform the chiropractor or certified assistant who is treating me of any sensitive areas or adverse conditions I may have had prior to, during, or after treatment. I intend this consent to cover the entire course of treatment.

We thank you for your patience and cooperation in completely filling out this form.

_____ _____

(Patient's Signature) (Today's Date)

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