Pregnancy
Wellness Profile

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Practice Member Information ______________________ File ______________

Name: ____
Appointment Date M ______ D ______ 20 ______ Birth Date M ______ D ______ Y ______
Home Address: ____
City ______________________________ State ______________ Zip ______________
Home Phone: ______________________________ May we leave a message? Yes No
Cell Phone: ______________________________ May we leave a message? Yes No
Work Phone: ______________________________ May we leave a message? Yes No
Email: ____
May we add you to our email newsletter and calendar of events? Yes No (Your email will not be shared)
Spouse's name? ____
Name(s) and age(s) of children: ____________ ____________ ____________ ____________
Occupation: ____
Do you primarily: Sit Stand Perform repetitive tasks
How did you hear about us? ____

Healthcare History

Have you had previous chiropractic care? No Yes
Who was your previous Chiropractor? ____
Where? ______________________ When? ______________________
Were X-rays taken in the last 6 months? Yes No
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 and postural issues
Wellness Care - Maximizing the body's ability for optimal healing and function
Do you feel your previous chiropractic care was effective? No Yes
Please explain: ____
Are you wearing: Heel Lifts Custom Orthotics
Family Doctor: ____
Date and reason of last visit: ____
May we contact your family doctor regarding your care at our office if necessary? No Yes
Naturopathic Doctor: ____
Date and reason of last visit: ____

Other Specialists and healthcare professionals:
Name: ____
Professional Designation: ____
Date and reason of last visit: ____
Name: ____
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? D_____M _____Y ______
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 ____________________
Have you had any evaluation procedures (ultrasound, amniocentesis, chorionic villus sampling)? No Yes
Dates and Reasons: ____________________
____
____
Have there been any stressful events in your life during this pregnancy? No Yes ____________________
____
____
What type of birth care provider are you planning on using? Midwife OB/Gyn Medical Doctor Other
Where do you plan on delivering? ____________________
Is this your first pregnancy? Yes No:
If not, how many pregnancies previously? ____________________
How many children do you have? ____________________
Miscarriages? No Yes: D&C Natural Miscarriage
How many vaginal deliveries? ____________________
How many caesarean sections? ____________________
Have there been any complications during your previous deliveries? No Yes ____________________
Was labor induced/use of Pitocin? 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 baby in a suboptimal position during the pushing phase of any labor? No Yes Unknown
Did you receive an epidural? No Yes
Were there any operative devices used? No Yes Forceps Vacuum
Any postpartum complications or long term consequences? No Yes ____________________
____

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/Mid Back Pain
		Chronic Fatigue			Breech or Sidelying Presentation
		Nausea/"Morning Sickness"			Round Ligament Pain/Pulling (front of belly)
		Heartburn/Indigestion			Pain in your Pubic Bone
		Preeclampsia			Pins/Needles in the Front/Side of your Leg
		Gestational Diabetes			Pain in Posterior Leg (Sciatica)
		Constipation			Leg Cramps
		Hemorrhoids			Swelling of Ankles, Legs and Feet

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Wellness Profile

Do you have a specific concern that brings you in?

No, I'm interested in having my spinal and pelvic alignment assessed to help achieve optimal growth and delivery for my baby

Yes: ______________________________

If yes, please answer the following questions:

What is your primary area of complaint today? ______________________________

How long have you been aware of this? __________ days __________ weeks __________ months __________ years

Where else does this pain go in your body? ______________________________

How often do you experience this? daily weekly monthly comes and goes constantly

On a scale of 1 to 10 (10 being the worst), how does it feel when it's at its worst? __________

How would you describe the pain/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/discomfort? __________

Do you feel your condition getting progressively worse? No Yes

Do you feel your condition can be healed? No Yes

What have you tried that **has** helped? Ice Heat Medication Massage Physical Therapy Chiropractic

Other ______________________________

What have you tried that **hasn't** helped? Ice Heat Medication Massage Physical Therapy Chiropractic

Other ______________________________

See additional ***Spinal Nerve Function Form*** to provide further detail on your *Wellness Profile* (**Page6**)

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 a ***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

Height __________ Weight __________

Are you happy with your current physical appearance and abilities? Yes No

Frequency of exercise/week: Cardio? 0 1 2 3 4 5 6 7

Weight bearing? . 0 1 2 3 4 5 6 7

Do you stretch after exercise or after other activities of poor posture? Yes Sometimes No

Hours of sleep/night? <6 7-9 10+

Do you feel refreshed upon waking? Always Sometimes Rarely

Age of mattress? ______ Do you feel your mattress is appropriate for your sleeping style? No Yes

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

Number of hours spent commuting/week? 0-2 3-5 6-8 9-11 12+

Number of hours spent at a desk or computer/week? 0 1-5 6-10 11-20 21-40 41+

Number of hours spent on smart device/tablet/week? 0 1-5 6-10 11-20 21-40 41+

Do you perform any 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 minor)? No Yes

If yes, what kind and when? ______________________________

Were you evaluated and treated after each accident? No Yes

Have you had any non-vehicle accidents or falls? No Yes ______________________________

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Early Years

To your knowledge, was your delivery difficult? No Yes
If yes: Forceps Vacuum Caesarean Breech Other____________________
Were you breast fed? No Yes For how long? ____________________
Did you experience emotional trauma as a child? No Yes ____________________
Were you ever given antibiotics as a child? No Yes ____________________
Did you ever have ear infections as a child? No Yes____________________
Any major childhood illness? No Yes ____________________

Emotional

Rate your current level of ***personal stress*** in your life: . . . . None Low Moderate High
Rate your current level of ***relationship stress*** in your life: . . . . . . None Low Moderate High
Rate your current level of ***financial stress*** in your life: . . . . None Low Moderate High
Rate your current level of ***health stress*** in your life: . . . . None Low Moderate High
Rate your current level of ***family stress*** in your life: . . . . None Low Moderate High
Rate your current level of ***career stress*** in your life: . . . . None Low Moderate High
Do you feel you have a supportive network of friends and family? . . . Yes No
Do you feel you have healthy coping strategies for life stress? . . . . . Yes No

Chemical

Were you vaccinated as a child? . . . . No Yes
Any adverse reactions to vaccines? . . . . No Yes____________________
Do you choose to have annual flu shots? . . . . No Yes
Do you take antibiotics? . . . . No Yes, How often? ____________
How many glasses of water/day:. 0 1-3 4-6 7-9 10+
How many glasses of caffeinated beverages/day: . . . . 0 1-3 4-6 7-9 10+
How many glasses of cow's milk, juice and pop/day: . . . . 0 1-3 4-6 7-9 10+
Do you eat gluten? . . . . No Yes Trying to eliminate from diet
Do you eat dairy? . . . . No Yes Trying to eliminate from diet
Do you eat refined sugars? (white sugar, white bread and pasta) . . . . No Yes Trying to eliminate from diet
Do you eat boxed/frozen foods?. No Yes Trying to eliminate from diet
Do you choose organic foods?. . . . . No Yes, which: Veggies Fruits Meats Grains All
Do you eat any artificial sweeteners? (Splenda, Aspartame, Diet Soda, etc) . No Yes
Any food/drink allergies, sensitivities, intolerances?. . . . . No Yes____________________
Do you smoke? . . . . No Yes I used to for__ years I wish I didn't
Are you or have you been exposed to second hand smoke? . . . . No Yes
Do you drink alcohol? . . . . No Yes 0-6/week 6-12/week 12+/week
Do you take a probiotic daily? . . . . No Yes, ______ CFU's/day
Do you take vitamin D3 daily? . . . . No Yes, ______ IU's/day
Do you take Omega 3 Fish Oils daily?. . . . . No Yes, ______ mg/day Capsule Liquid
Other supplements or homeopathics? ____________________
Any other daily medication and their purpose? ____________________
____
Do you have a plan in place with your medical doctor to wean yourself off of any long term medications? No Yes

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Family Health

At our clinic we are not only interested in your health and wellness, but also the health and wellness of the important people in your life. Please mention below any health conditions or concerns you may have about your:

Children: ____

Spouse: ____

Mother: ____

Father: ____

Brothers/Sisters: ____

Are you seeking chiropractic care today for:

- Relief Care - Symptom relief of pain or discomfort
- Corrective Care - Correcting, relieving and stabilizing spinal, joint and postural issues
- Wellness Care - Maximizing the body's ability for optimal healing and function of the nervous system
- Pregancy Care: regular care throughout pregnancy to optimize the growth and development of my baby and prepare my body for a healthy delivery and fast recovery.

Do you have other concerns we should know about? ____

____

____

____

____

____

____

____

____

____

Goals & Consent

What is your primary goal for consulting our clinic? ____

Our goals are to provide a detailed assessment of your current health status and provide to you the resources for a highly engaged and healthy body which is functioning at its absolute peak potential. Essential to this is a healthy nervous system functioning free from interference called subluxations. You've taken an important step for your health through a chiropractic evaluation!

Consent to Evaluation

I ____ hereby grant permission to receive a chiropractic evaluation including history, spinal scan and examination. Any findings will be communicated before consenting to commencement of care, if appropriate.

____ ____

Consenting Adult's Signature Date

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SPINAL NERVE

ORGANS & GLANDS

The organs and glands listed below are linked to the corresponding sections of the spine and it's spinal nerves.

ASSOCIATED SYMPTOMS

Please indicate below any symptoms you are currently experiencing as well as any you have previously experienced.

Spinal Nerve	Organs & Glands	Current	Previous	Associated Symptoms	Current	Previous	Associated Symptoms
CERVICAL: C1, C2, C3, C4, C5, C6, C7, C8; THORACIC: T1	Parotid Gland • Scalp Base of Skull • Eyes Lacrimal Gland • Sinuses Inner, Middle & Outer Ear Nose • Mouth Intracranial Blood Vessels Sympathetic Nervous System Neck Muscles • Diaphragm Shoulders • Elbows • Arms Wrists • Hands & Fingers Tonsils • Vocal Cords Esophagus • Heart Lungs • Chest • Thyroid			Sinus & Ear Pain/Infection Runny Nose & Allergies Frequent Head Colds Sore Throat & Tonsilitis Strep Throat Chronic Cough & Croup Difficulty Breathing Poor Immunity Dizziness & Vertigo Tinnitus & Ear Fullness Vision Problems Watery/Dry Eyes Chronic Fatigue Poor Concentration Depression			Anxiety & Stress Seizures ADD/ADHD Thyroid Dysfunction Metabolic Dysfunction Insomnia High/Low Blood Pressure Enlarged Lymph Glands Migraines & Headache TMJ Pain Stiff Neck Arm Pain Hand/Finger Numbness Loss of Grip Strength
THORACIC: T2, T3, T4, T5, T6, T7, T8, T9, T10, T11, T12	Arms • Wrists Esophagus • Chest • Heart Lungs • Trachea • Larynx Diaphragm • Stomach Gallbladder • Liver Pancreas • Small Intestine Spleen • Kidneys • Appendix Adrenals • Colon • Buttocks Uterus • Ovaries • Testes			Asthma Bronchitis & Pneumonia Congestion Reflux & GERD Indigestion & Heartburn Stomach Pains Ulcers Gas & Bloating Jaundice Liver Conditions Blood Sugar Dysregulation			Kidney Stones Gall Bladder Attacks Skin Conditions & Rashes Menstrual Cramps/PMS Infertility Menstrual Dysfunction Rashes & Eczema Hyperactivity Shoulder Pain Midback Pain Rib Pain
LUMBAR: L1, L2, L3, L4, L5	Large Intestine • Colon Thighs • Buttocks • Groin Knees • Legs • Feet Reproductive Organs			Irritable Bowel, Colitis, Crohn's Gas Pain & Constipation Diarrhea Hemorrhoids Bladder Infections Bladder Incontinence & Bedwetting Painful/Excessive Urination			Prostate Dysfunction & Impotence Ovarian Cysts & Endometriosis Fertility Problems/ Loss of Menstruation Low Back Pain Hip Pain Thigh Pain Numbness & Tingles in Legs
SACRAL: S1, S2, S3, S4, S5	Buttocks • Groin • Legs Ankles • Feet • Toes Prostate Gland • Bladder Reproductive Organs			Varicose Veins Leg Cramping Restless Legs Poor Circulation & Cold Feet			Sciatica Pelvic Pain Knee Pain Ankle Pain & Sprains Foot Pain & Weak Arches

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