PREGNANCY HEALTH HISTORY

Name_________________________ DOB_________ Age__________

Address_________________________City_______________State_________Zip___________

Home Phone _______________Work Phone_______________Cell Phone _______________

□ Single □ Married □ Divorced □ Widowed # of Children & Ages _______________

SS# _______-_______-___________ E-mail_________________________

Employer _______________Occupation (describe) _______________

Spouse's Name _______________ Spouse's Occupation_______________

Whom may we thank for referring you?_______________ □ Phone Book □ Website □ Sign □ Other_______________

Prenatal History: *(circle, highlight or write where applicable)*

1) Is this your first pregnancy? Yes No How many other births have you had? _______________
2) How many weeks pregnant are you?_______wks What is your estimated due date? _______________
3) If you are in your 3rd trimester, what position is your baby in? Vertex (head down) Breech (see below)
4) Were there any challenges trying to conceive for this pregnancy? Yes No _______________
5) Where do you plan on delivering? Home Birthing Center Hospital Other_______________
6) Who is your birth care provider? Lay Midwife Nurse Midwife OBG Name_______________
7) Who will you have with you at birth for support?_________________________
8) Have you put together a birth plan? Yes No
9) Have you experienced any traumas (accidents, falls) during this pregnancy? Yes No
   Please describe:_________________________
10) Have you had any evaluation procedures (ultrasound, amniocentesis, chorionic villus sampling)? Yes No
    Dates / frequency & reasons:_________________________
    ____
11) Have there been any stressful events in your life during this pregnancy? Yes No
    Please describe:_________________________
12) What are your most significant concerns associated with this birth?_________________________
13) Are you taking any prenatal supplements? Yes No (multi, fish oil, vit D)_______________
14) Any medications during this pregnancy? Yes No _________________________

Present State of Health (presenting symptoms): Most pregnant women visit our office to give themselves and their baby the best opportunity to have a natural vaginal birth. However, some women also experience symptoms during their pregnancy. If you have a specific concern, please complete the following section. If you are here for a wellness visit, skip to the next section. *(circle, highlight or write where applicable)*

If this visit is concerning a breech presentation, please complete the following:

a. What position is your baby in now? Transverse Complete Footling Frank Kneeling Other_______________
b. Was it confirmed by ultrasound? Yes No When was the last test to confirm the baby's position?_________
c. At what gestational week did you first learn your baby was breech?_________Wks
d. Have you tried any procedures or maneuvers yet? Yes No Explain:_______________
e. Are you familiar with the chiropractic Webster Technique? Yes No

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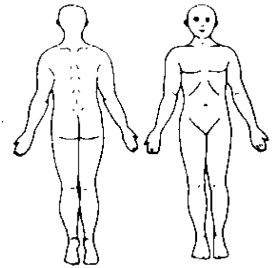
1st Complaint____

a. Been a problem for: ______Day(s) ______Week(s) ______Month(s) ______Year(s)

b. Quality of symptom is: Sharp Dull Numb Tingling Burning Stiff Other______________

Mark areas below



c. Condition came on: Sudden Gradual It is getting: Better Worse No Change

d. Condition is: Constant Comes & Goes Feels worse in: AM Noon PM In Bed

e. Does it radiate? Yes No Where:______________________________________

f. On a scale of 1-10 *(10 = worst)* the pain at its worst is:____________________________

g. What makes it better?____

h. What makes it worse?____

i. Have you seen anyone for this? Yes No Who?_______________________________

j. How does it interfere with your life (sleep, work, play, lifting children, etc.)______________________________

____

Other Complaints *(Please briefly describe)*____

____

Are ANY of the above complaints related to an auto or work injury? Yes No____________________________

Wellness Profile: Chiropractic care affects more than just muscles, joints and how we feel. Chiropractic helps our bodies function at a higher level which increases our overall health and wellness. Please share with us what health goals you hope to achieve. *(Circle as many goals as you wish)*

More Energy	Better Sleep	Freedom from Pain
Easier Breathing	Improved Posture	Improved Nutrition & Diet
Improved Coordination	Eliminate Medications	Improved Overall Health
Better Sports Performance	Stress Reduction	Better Concentration
Stronger Immune System	Other____________________________	

Spinal Health: *(circle, highlight or write where applicable)*

1) Have you ever visited a doctor of chiropractic before? Yes No Who?____________________________

   When was your last visit?________________ Reason for ending care?____________________________

2) Have you ever had spinal x-rays taken? Yes No When?___________ Were you standing? Yes No

3) Circle/explain if you have: Scoliosis Spinal Arthritis Inherited Spinal Problem__________________________

4) Spinal misalignments cause decay and degeneration which results in grinding or cracking.

   Do you ever hear noises when you move your head or neck? Yes No

5) Spinal misalignments can make you feel the need to twist, stretch or crack your neck or spine.

   Do you ever feel the need to twist, stretch or crack your neck or spine? Yes No

6) Poor posture leads to poor health and often indicates spinal problems. Please rate your posture.

   Poor - 1 2 3 4 5 6 7 8 9 10 - Excellent

7) Stress can cause or accelerate spinal damage. Rate your stress level over the last 90 days.

   Low - 1 2 3 4 5 6 7 8 9 10 - High

8) Have you ever had spinal surgery? Yes No If yes, when & where? ____________________________

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Overall Health History: *(circle, highlight or write where applicable any **past or present** health challenges)*

ADD / ADHD	Allergies	Arthritis	Asthma	Cancer
Constipation	Diarrhea	Diabetes	Digestive Issues	Epilepsy
Eating Disorder	Heart Disease	Herniated Disc	Migraines	Headaches
Learning Disorder	High Cholesterol	Pinched Nerve	Osteoporosis	Stroke
Repeat Infections	Frequent Colds	Fibromyalgia	Sinus Problems	Acid Reflux
Thyroid Problems	Tumor/Growth	Depression	RA	MS

Menstrual Problems_____________________________Sleeping Problems____

OTHER____

Do you exercise: Yes No How often: __________________Type:______________________________________

Do you smoke: Yes No How often: Daily Weekly Occasional

Do you drink caffeine Yes No How often: Daily Weekly Occasional

Do you drink alcohol: Yes No How often: Daily Weekly Occasional

List any allergies:____

Current medications: ____

Please rate the following as (P) Poor, (G) Good or (E) Excellent:

Diet – P G E Sleep – P G E Mental State – P G E General Health – P G E

Injuries/Surgeries: *(Date & Description)*

Auto Accidents:____

Recreational Accidents:____

Fractures / Dislocations:____

Surgeries:____

Family History:

Does anyone in your family suffer with any of the following conditions? *(Please circle or highlight Father &/or Mother)*

F M Heart Disease F M Stroke F M Cancer (types):____

F M High BP F M Thyroid F M Neurological *(Parkinson's, ALS, MS)* other________________________

F M Diabetes F M Asthma F M Other____

Would you like to receive our health and wellness newsletter (1-2 times per month via email)? Yes No

(Topics include: diet, exercise, stress management, women's and children's health, wellness topics, etc.)

The above information is true and accurate to the best of my knowledge. I understand that I am directly and fully responsible to BC Family Chiropractic for all fees associated with chiropractic care.

____ ________________ Reviewed by:__________

Patient Signature Date Dr. Initials

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ACTIVITIES OF DAILY LIVING

In order to properly assess your condition, we must understand how much your health problems have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition currently.**

Item	0	1	2	3	4
1) **Pain Intensity:**	None	Mild	Moderate	Severe	Unbearable
2) **Frequency of Pain:**	None	25% of the day	50% of the day	75% of the day	Constant
3) **Lifting:**	No Pain w/ Heavy Weight	Increased Pain w/ Heavy Wt.	Increased Pain w/ Moderate Wt.	Increased Pain w/ Light Wt.	Increased Pain w/ Any Wt.
4) **Walking:**	No Pain w/ Any Distance	Increased Pain After 1 Mile	Increased Pain After ½ Mile	Increased Pain After ¼ Mile	Increased Pain w/ Any Distance
5) **Standing:**	No Pain After Several Hours	Increased Pain After Several Hours	Increased Pain After 1 Hour	Increased Pain After ½ Hour	Increased Pain w/ Any Standing
6) **Travel:** (Driving)	No Pain on Long Trips	Mild Pain on Long Trips	Moderate Pain on Long Trips	Moderate Pain on Short Trips	Severe Pain on Short Trips
7) **Work:**	Do Usual Work + Unlimited Extra	Do Usual Work But No Extra	Can do 50% of Usual Work	Can do 25% of Usual Work	Cannot Work
8) **Sleeping:**	Perfect Sleep	Mildly Disturbed	Moderately Disturbed	Severely Disturbed	Totally Disturbed
9) **Personal Care:** (Washing, Dressing, etc.)	No Pain	Mild Pain	Moderate Pain	Severe Pain	Unbearable Pain
10) **Recreation:**	Can do All Activities	Can do Most Activities	Can do Some Activities	Can do Few Activities	Cannot do Any Activities

Patient Signature:______________________________ Date:________________ Score:_________