File No: _____

PREGNANCY INTAKE FORM

Title	Surname:		Given names:	Preferred:
Date of Birth:	Height:	Weight:	Occupation:	Marital Status:
Address:			Suburb:	Postcode:
Email:			Mobile:	Home:
Emergency Contact:		Mobile:		Relationship:
How did you hear about us? (eg friend; google etc) Who may we thank:			Names and ages of children:	
Private health insurance provider:			Is this in relation to*: (Circle if applicable)* DVA / Workers Comp / Motor Vehicle*)*	
General Practitioner Name:		Contact Number:	Address:	

Why this form is important:
Our focus is on assisting clients to function optimally, for them to become more self-aware, stronger, healthier and for improved adaptation to everyday stresses. Completion of this form provides us with an improved understanding of your physical, emotional and chemical stresses that can gradually overwhelm the body over time and contribute to health problems. Please complete this form as thoroughly as possible and we will review it with you. Information on this from is strictly confidential and will not be shared without your consent.

CASE HISTORY: Please check this box if there are no current concerns and this assessment is to ensure optimum health, function and wellness ☐

Current Health Concern: _____

ABOUT YOUR PREGNANCY: (circle your answers please)
Is this your first pregnancy? Yes / No
If this is not your first, how many times have you been pregnant? _____
Have you had any complications with previous pregnancies? Yes / No (explain below if yes)
_____
If you have had miscarriage(s), how far along in your pregnancy did it/they occur?
_____
Was this pregnancy planned? Yes / NO
What is the estimated date of delivery? _____
Who is your primary care giver for delivery? Obgyn / GP / Midwife? Name: _____
What is your planned location for delivery? Hospital / Home / Birthing Centre / Other: _____
How do you feel about this pregnancy? _____
Have you established a birth plan? Yes / No
Would you like more information on creating one? Yes / No
Any special arrangements for the birth? (planned c-section, water delivery, birth chair, squat, other):
_____
Would you like additional information on options for birth posturing? Yes / No
Have you had any testing? Genetic, blood, ultrasound, amniocentesis, chorionic villi sampling, other:
Dates and reasons: _____

Are you planning on breastfeeding post delivery? Yes / No
Would you like further information on the advantages of breastfeeding ? Yes / No
Was your blood pressure prior to pregnancy within normal range, low or high? _____
What is your present blood pressure and when was it last checked? _____
Have you changed your diet / menu since learning of your pregnancy? Yes / No
Would you like further information on healthy nutrition for pregnancy? Yes / No
Have you smoked prior to or along with this pregnancy? Yes / No / Quit _____
Have you had alcohol during this pregnancy? Yes / No _____

Have you noticed?
Swelling in the arms or legs? Yes / No _____
Low back pain? Yes / No How often? _____
Upper back pain? Yes / No How often? _____
Neck pain? Yes / No How often? _____
Rib or chest pain? Yes / No How often? _____
Any foot pain? Yes / No How often? _____
Digestive complaints? Heartburn, constipation? Yes / No _____
Nausea or vomiting? Yes / No Frequency and when? _____
Arm or hand numbness/tingling? Yes / No How often? _____
Dizziness or light-headedness? Yes / No How often? _____
Headaches? Yes / No How often? _____
Pain radiating down the leg(s)? Yes / No How often? _____
Heart palpitations? Yes / No How often? _____
If pain from anything noted above is involved, rank it on a scale of 1 to 10 (1 is minimal and 10 is extreme) _____/10
Circle (or describe) its character: **sharp, dull, ache, burning, tingling, throbbing, spasms**
When did you notice it? _____
What happened? _____ What relieves? _____
What aggravates? _____
Does it radiate or cause problems elsewhere? _____
Any associated or related concerns? _____
Professionals seen for this? (name) _____
Treatment and results: _____

Other Health Concerns: Please note all other health concerns present or in the past.

	Past	Present		Past	Present		Past	Present
Allergies			Stuffy Nose			Runny Sinuses		
Frequent Colds			Lowered resistance			Loss of balance		
Difficulty concentrating			Fatigue			Indigestion		
Bloating			Appendicitis			Asthma		
Bronchitis			Emphysema			Pneumonia		
Bleeding disorder			Cancer			Cataracts		
Vision changes			Diabetes			Hypoglycaemia		
Epilepsy			Heart disease			Hypertension		
Migraines			Hepatitis			High cholesterol		
Digestive Difficulties			Loose stools			Hernia		
Disc herniation			Kidney disease			Liver disease		
Multiple sclerosis			Osteoarthritis			Rheumatoid arthritis		
Osteoporosis			Parkinson's disease			Thyroid Problem		
Tonsillitis			Ulcers			UTI		
Ulcerative colitis								

Other:

PHYSICAL STRESSES

Any significant injuries, falls or traumas? Yes / No / unsure (if yes please explain):

_____

Any hospital visits? Yes / No Explain: _____

Have you had any surgeries or fractures? Yes / No Explain: _____

_____

Are you in prolonged postures (eg repetitive work, lifting, sitting, driving)? Yes / No / Unsure

Explain: _____

Any hobbies that are physically strenuous or have repetitive movements? Yes / No / Unsure

Explain: _____

What is your usual exercise routine? _____

Any vehicle accidents? Yes / No Details if yes: _____

_____

CHEMICAL STRESSES

Are you taking any prescription or over-the-counter medications? Yes / No (If yes, please indicate what you are taking and why)

_____

_____

Are you currently taking any supplements (eg vitamins)? Yes / No (If yes, which ones and why)

_____

_____

MENTAL / EMOTIONAL STRESSES

Since psychological stress has been shown to affect numerous systems and foetal function, please let me know how you are coping with life's stresses. Please rank from 1 to 10, with 1 being minimal stress to 10 being extreme.

Life in general _____	Work & Career _____	Relationships _____
Financial Stress _____	Time Management _____	Sports & hobbies _____
Health & Wellness _____	Quality of Sleep _____	My Pregnancy _____

If you are experiencing significant or ongoing stress please explain:

_____

_____

Do you practice some form of meditation, breath work, other mind-body movement or have a routine to reduce your stress? Yes / No

Explain: _____

_____

Are you interested in learning about stress reduction practices? Yes / No

FAMILY HEALTH HISTORY

Please note any health issues that are present with family members such as parents, siblings, significant others or children. Cancer, hypertension, stroke, arthritis, kidney disease, dementia, other.

_____

_____

WHY ARE YOU HERE?

People seek chiropractic care for a number of reasons and have certain expectations and perceptions. Please tick the goals which apply to you so we can accommodate your wishes. (Select all that are appropriate).

Improvement if function			Pain reduction	
Improve quality of life			Manage my crisis	
Symptom management			Healthy immune system	
Keep me moving			Optimum nervous system function	
Wellness			Longevity	
Relief			Stress reduction	
Prevention			Improve performance	
Other:				

Acknowledgment of Office Policy & Consent to Procedures

I have read and understand the Office Fee Policy document. I understand that as part of clinic policy, if cancellation or rescheduling is not given by 4pm on the day prior to my appointment, the full amount will be charged.

Name: **_____**

Signature: _____ Date: _____