CLAYTON PARK CHIROPRACTIC CENTRE INC.
Suite 11-117 Kearney Lake Road
Halifax, Nova Scotia
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Pregnancy Health History Form

Name: _____ Date: _____

Age: _____ Birth date: mm/dd/yyyy_____ Sex: F No. of Children _____

E-mail address: _____

Address: _____

Phone: (H)_____ (W) _____(C)_____ Marital status: S M W D CL

We offer text reminders for appts. If interested, who is your cell phone provider?_____

Occupation:_____ Who may we thank for referring you? _____

Family doctors name and address: _____

Emergency Contact: _____ Phone #: _____ Relationship: _____

WHY THIS FOR 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 will provide 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 the doctor will review it with you. Information on this form is strictly confidential and will not be shared without your consent.

Current Health Concern (if there are no current concerns and this assessment is to ensure optimum health, function and wellness tick this box) ☐

About your pregnancy: (circle answer)
Is this your first pregnancy? Yes/ No
If this is not your first, how many times have you been pregnant? _____
Have you had any complaints with previous pregnancies? Yes / No (explain if yes)

If you have had miscarriage(s), how far along in your pregnancy did it occur?

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 clinic / other
How do you feel about this pregnancy? _____
Do you have you a birth plan? Yes / No Would you like 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 breast feeding? 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...

	Yes/No	How Often?	When did you notice it?	Rank it on a scale of 1-10	Describe it's character (sharp, dull, ache, burning, tingling, throbbing, spasms, other...)	What aggravates?	What relieves?	Does it radiate or cause problems elsewhere?
Swelling in the arms or legs?								
Low back pain?								
Upper back pain?								
Neck pain?								
Rib or chest pain?								
Any foot pain?								
Digestive complaints? Heartburn, constipation?								
Nausea or vomiting?								
Arm or hand numbness/tingling?								
Dizziness or lightheadedness?								
Headaches?								
Pain radiating down the leg(s)?								

Any associated or related concerns? _____
Professionals seen for this? (name) _____
Treatment and results _____

In the diagrams below, please mark the areas on your body, which you feel best represents the pain(s) or sensation(s) that you experience. Please include all areas. (Use the symbols provided below).

Numbness ≡

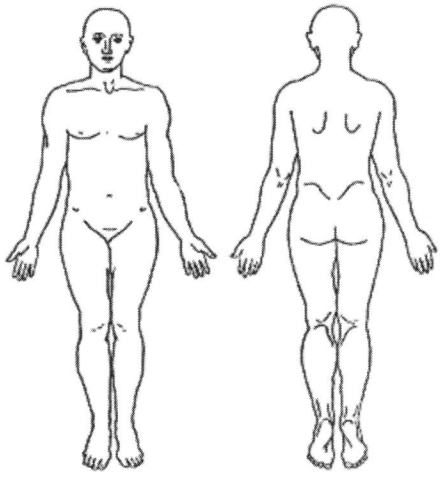
Pins & Needles ****

Sharp & Stabbing / / / / / /

Burning XXXXXX

Dull & Aching + + + + + +

Stiff & Tight 222222



Other health concerns: *Please circle all health concerns present or in the past*

Allergies, Stuffy nose, Runny sinuses, Frequent colds, Lowered resistance, Loss of balance, Difficulty concentrating, Fatigue, Indigestion, Bloating, Appendicitis, Asthma, Bronchitis, Emphysema, Pneumonia, Bleeding disorders, Cancer, Cataracts, Vision changes, Diabetes, Hypoglycemia, Epilepsy, Heart Disease, Hypertension, Migraines, Hepatitis, High cholesterol, Difficulty digestion, Loose stools, Hernia, Herniated Disc, Kidney disease, Liver disease, Multiple Sclerosis, Osteoarthritis, Osteoporosis, Parkinson's disease, Thyroid problem, Tonsillitis, Ulcers, Urinary tract infections, Ulcerative colitis, Other (list):

Fatigue, headaches with physical and mental stress, weak immune, allergies, slow to start in a.m., gastric ulcers, afternoon headaches, feeling full/bloated, cravings sweet/caffeine/cigarettes, blurred vision, shaky with missed meals, irritability before meals, eating to relieve fatigue, cannot fall/stay asleep, dizziness from moving up and down, spells of dizziness, asthma, hemorrhoids, varicose veins, unstable behavior

Feeling tired or sluggish, feeling cold (hands, feet, all over), requires excessive amounts of sleep, weight gain despite efforts, gain weight easily, infrequent bowel movements, morning headaches resolving throughout the day, outer 1/3 of eyebrow thinned, thinning of hair on scalp, face, genitalia, dryness of skin and/or scalp, mental sluggishness, depression and lack of motivation.

Physical stresses

Any significant injuries, falls or traumas during infancy or childhood? Yes No Unsure
(if yes explain) _____
Any significant injuries, falls or traumas (car accidents) during adulthood? Yes No Unsure
(if yes explain) _____
Any hospital visits? Yes / No
Explain _____
Have you had any surgeries, fractures? Yes No Explain and dates _____
Are you in prolonged postures (ex: repetitive work, lifting, sitting driving) Yes No Unsure
(if yes, please explain)_____
Any hobbies physically strenuous or have repetitive movements? Yes No Unsure
(if yes, please explain)_____
What is your usual exercise routine? _____
Any fractured bones or dislocations? _____
Any vehicle accidents? Yes No What happened and when? _____

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

Are you currently taking supplements? Yes / No (if yes, which ones and why?)

Mental/Emotional Stresses

Since psychological stress has been shown to affect numerous systems, please let us know how you are coping with life's stresses. Rank from 1 to 10 (1 being the minimal and 10 being extreme)

Life in general I feel ____ Work and Career I feel ____ Relationships I feel ____
Financial stress I feel ____ Time management I feel ____ Sports & hobbies I feel ____
Health and well-being I feel ____ Quality of sleep I feel ____ About my pregnancy I feel ____

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 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 other or children. Cancer, hypertension, stroke, arthritis, kidney disease, dementia, diabetes, 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.

Improving in function ____ Pain reduction ____ Relief ____ Improved quality of life ____

Manage my crisis ____ Information on prevention ____ Symptom management ____

Healthier immune system ____ Stress reduction ____ Keep me moving ____ Wellness ____

Optimum function and quality of life ____ Improved performance ____ Full body integration ____

Longevity _____ Other _____

OFFICE FEE SCHEDULE & FINANCIAL POLICY
(Chiropractic prices are *not* subject to tax)

CHIROPRACTIC SERVICES:

	Dr. Doug + Dr. Sasha
Consultation (10min)	*NO CHARGE*
Initial Chiro Exam	$100.00
Chiro Adjustment	$65.00
Chiro Re-Assessment	$75.00
Chiro Reactivation	$75.00
Missed Appointment Charge	**$45.00**

FINANCIAL POLICY AND CHIROPRACTIC ACTIVE LIFE PLANS
We are committed to providing you with the best chiropractic care possible in a caring environment and have established our financial policies to achieve that goal. You will be expected to pay for your chiropractic care at the time the service is rendered unless you arrange a Chiropractic Active Life Plan in advance. These plans are designated to be the most cost effective way to keep you and your family as healthy as possible. Details of these plans will be discussed with you during your Report of Findings appointment.

REGISTERED MASSAGE THERAPY SERVICES:

½ HOUR SESSION (specific area)	$56.52 (plus tax) = $65.00
1 HOUR SESSION	$86.96 (plus tax) = $100.00
1 ½ HOUR SESSION	$134.78 (plus tax) = $155.00
2 HOUR SESSION	$173.91 (plus tax) = $200.00

If less than 24 hours notice is given to cancel Massage Therapy, a FULL APPOINTMENT FEE will be charged

NO DIRECT BILLING – Our office does NOT direct bill to any insurance company therefore **PAYMENT IN FULL IS DUE** on date of service.

We accept exact cash, debit or credit cards (Visa & Mastercard only)

This office is **SCENT SENSITIVE.** Please refrain from wearing strong perfumes and aftershaves during your visit.

I, (printed name) _____ have read and I understand the above policies.

_____ _____

Patient signature (or guardian) **Date**