



Dr. Initials \_\_\_\_\_

## PATIENT INFORMATION – PREGNANCY INTAKE AND HEALTH HISTORY

Patient Name \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Address \_\_\_\_\_

Name and Ages of Children \_\_\_\_\_

City \_\_\_\_\_ Postal Code \_\_\_\_\_

Phone # \_\_\_\_\_

### IN CASE OF EMERGENCY, CONTACT

Email \_\_\_\_\_

Name \_\_\_\_\_

I do not want to be contacted through email

Relationship \_\_\_\_\_

Gender \_\_\_\_\_ Age \_\_\_\_ Date of Birth \_\_\_\_\_

Contact Number \_\_\_\_\_

Employer/School \_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_

Occupation \_\_\_\_\_

Have you ever received chiropractic care?  Yes  No

Alberta Health Care # \_\_\_\_\_

If yes, who and approximately when? \_\_\_\_\_

## HOW CAN WE HELP YOU?

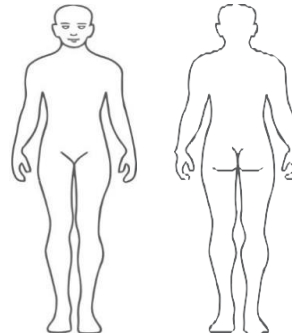
What brings you in today?  Wellness Checkup  Specific concern  Pregnancy-related symptom

If you are already experiencing a symptom(s), what is it? \_\_\_\_\_

How bad is it? How intense are your symptoms? (circle) **0** **1** **2** **3** **4** **5** **6** **7** **8** **9** **10**  
NO SYMPTOMS INTENSE SYMPTOMS

Please **circle** areas to the right where you have pain or other symptoms:  
What does it feel like? (check all that apply)

- Numbness
- Sharp
- Tingling
- Shooting
- Stiffness
- Burning
- Dull
- Throbbing
- Aching
- Stabbing
- Cramping
- Swelling
- Nagging
- Other



Is this related to a Motor Vehicle Accident **in the last 10 days**?  No  Yes, date of accident \_\_\_\_\_

Is this a work-related injury (WCB claim)?  No  Yes | Do you wear orthotics or special shoe inserts?  No  Yes

**As a result of chiropractic care, I would like to achieve: (check all that apply)**

- Symptom relief
- Correction of underlying cause
- Prevention of future problems
- General wellness

## PREGNANCY - SPECIFIC

### Previous birth experience

Is this your first pregnancy?  Yes  No

If No, how many times have you been pregnant? \_\_\_\_\_

Have you had any serious complications in previous pregnancies?  No  Yes, explain \_\_\_\_\_

Do you wish to follow the same plan as your previous delivery?  Yes  No, explain \_\_\_\_\_

### Early pregnancy

When is your expected or calculated due date? \_\_\_\_\_

Have you had any unusual weight gain or weight loss during this pregnancy?  Yes  No

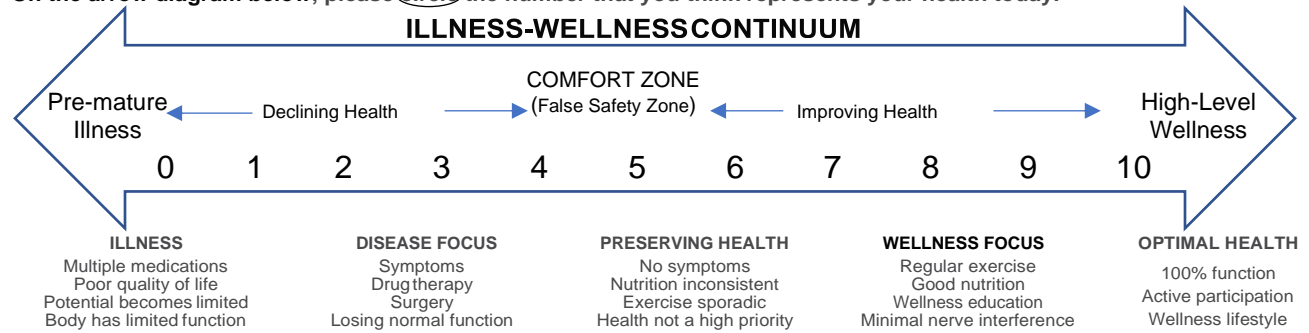
Have you experienced any morning sickness?  Yes  No

If yes, how would you rate your morning sickness?

- Typical for normal pregnancy
- Atypical for normal pregnancy

## PATIENT WELLNESS ASSESSMENT

Our health is constantly changing based on the health decisions we make on a daily basis. On the arrow diagram below, please circle the number that you think represents your health today.



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

\_\_\_\_\_

## TRAUMA HISTORY (Previous injuries and accidents can affect how our body can regain its strength.)

Have you ever had any of the following (check all that apply and describe/date)

Prior to pregnancy	During pregnancy	
<input type="checkbox"/>	<input type="checkbox"/>	Slips and falls _____
<input type="checkbox"/>	<input type="checkbox"/>	Head injuries/Concussions _____
<input type="checkbox"/>	<input type="checkbox"/>	Motor Vehicle Accidents _____
<input type="checkbox"/>	<input type="checkbox"/>	Surgeries _____
<input type="checkbox"/>	<input type="checkbox"/>	Broken Bones _____
<input type="checkbox"/>	<input type="checkbox"/>	Major emotional stressors _____
<input type="checkbox"/>	<input type="checkbox"/>	Other _____

Is there a family history of (check all that apply)

- Heart Disease       Stroke       Cancer       Diabetes

Allergies, medications, supplements (please list): \_\_\_\_\_

## LIFESTYLE STRESSES (What we do on a daily basis affects how quickly our body can adapt and heal.)

Physical Stressors	Chemical Stressors	Emotional Stressors
What do you spend most of your day doing? (check all that apply) <input type="checkbox"/> Sitting <input type="checkbox"/> Driving <input type="checkbox"/> Standing <input type="checkbox"/> Walking <input type="checkbox"/> Lifting	Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No My caffeine intake is: <input type="checkbox"/> Low <input type="checkbox"/> Moderate <input type="checkbox"/> High My diet is: <input type="checkbox"/> Healthy <input type="checkbox"/> Ok <input type="checkbox"/> Poor	My mental stresses include: (check all) <input type="checkbox"/> Work <input type="checkbox"/> Finances <input type="checkbox"/> Home <input type="checkbox"/> Health <input type="checkbox"/> School <input type="checkbox"/> Children <input type="checkbox"/> Family <input type="checkbox"/> Relationships Rate your sleep <input type="checkbox"/> Great <input type="checkbox"/> Poor <input type="checkbox"/> Ok <input type="checkbox"/> Awful How many hours per week do you work? _____
How often do you exercise? <input type="checkbox"/> Daily <input type="checkbox"/> <1x/week <input type="checkbox"/> 2-3x/week <input type="checkbox"/> Never <input type="checkbox"/> 1x/week	Rate your chemical stress (1=low,10=high) 1-----5-----10	Rate your emotional stress (1=low,10=high) 1-----5-----10
Rate your posture <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Poor Rate your physical stress (1=low,10=high) 1-----5-----10		

# Patient Review of Systems

Please check the corresponding boxes for each symptom or condition you have experienced – including both past and present



REGIONS	FUNCTIONS	SYMPTOMS					
		Past	Present		Past	Present	
<b>Cervical</b>	• Autonomic Nervous system	<input type="checkbox"/>	<input type="checkbox"/>	Ear & Sinus Infections	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy & Seizures
		<input type="checkbox"/>	<input type="checkbox"/>	Allergies & Congestion	<input type="checkbox"/>	<input type="checkbox"/>	Sensory & Spectrum
	• ENT System	<input type="checkbox"/>	<input type="checkbox"/>	Immune Deficiency	<input type="checkbox"/>	<input type="checkbox"/>	ADD / ADHD
		<input type="checkbox"/>	<input type="checkbox"/>	Headaches & Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Focus & Memory Issues
	• Vision, Balance & Coordination	<input type="checkbox"/>	<input type="checkbox"/>	Vertigo & Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety & Stress
		<input type="checkbox"/>	<input type="checkbox"/>	Sore Throat & Strep	<input type="checkbox"/>	<input type="checkbox"/>	Balance & Coordination
	• Speech	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Tonsils & Adenoids	<input type="checkbox"/>	<input type="checkbox"/>	Speech Issues
	• Immune System	<input type="checkbox"/>	<input type="checkbox"/>	Vision & Hearing Issues	<input type="checkbox"/>	<input type="checkbox"/>	TMJ / Jaw Pain
	• Digestive System	<input type="checkbox"/>	<input type="checkbox"/>	Low Energy & Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Stiff Neck & Shoulders
	• Nerve Supply to Shoulders, Arms & Hands	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Sleeping	<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>		<input type="checkbox"/>	Pain, Numbness & Tingling in Arms to Hands	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	
	• Metabolism	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	Poor Metabolism	
<b>Upper Thoracic</b>	• Upper G.I.	<input type="checkbox"/>	<input type="checkbox"/>	Reflux / GERD	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis & Pneumonia
	• Respiratory Function	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Colds & Coughs	<input type="checkbox"/>	<input type="checkbox"/>	Functional Heart Conditions
		<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Upper back discomfort
• Cardiac Function							
<b>Mid Thoracic</b>	• Major Digestive Center	<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder Pain / Issues	<input type="checkbox"/>	<input type="checkbox"/>	Indigestion & Heartburn
		<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Pains & Ulcers
	• Detox & Immunity	<input type="checkbox"/>	<input type="checkbox"/>	Fever	<input type="checkbox"/>	<input type="checkbox"/>	Blood Sugar Problems
<b>Lower Thoracic</b>	• Stress Response	<input type="checkbox"/>	<input type="checkbox"/>	Behavior Issues	<input type="checkbox"/>	<input type="checkbox"/>	Allergies & Eczema
	• Filtration & Elimination	<input type="checkbox"/>	<input type="checkbox"/>	Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	Skin Conditions / Rash
		<input type="checkbox"/>	<input type="checkbox"/>	Chronic Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems
	• Gut & Digestion	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Stress	<input type="checkbox"/>	<input type="checkbox"/>	Gas Pain & Bloating
• Hormonal Control							
<b>Lumbar, Sacrum &amp; Pelvis</b>	• Lower G.I. (Absorption & Motility)	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Sciatica & Radiating Pain
		<input type="checkbox"/>	<input type="checkbox"/>	Crohn's, Colitis & IBS	<input type="checkbox"/>	<input type="checkbox"/>	Lumbopelvic / SI Joint Pain
		<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Hamstring Tightness
	• Gut-Immune System	<input type="checkbox"/>	<input type="checkbox"/>	Bladder & Urinary Issues	<input type="checkbox"/>	<input type="checkbox"/>	Disc Degeneration
		<input type="checkbox"/>	<input type="checkbox"/>	Cramps & Menstrual Issues	<input type="checkbox"/>	<input type="checkbox"/>	Leg Weakness
		<input type="checkbox"/>	<input type="checkbox"/>	Cysts & Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>	Leg Cramps / Spasms
	• Major Hormonal Control	<input type="checkbox"/>	<input type="checkbox"/>	Infertility	<input type="checkbox"/>	<input type="checkbox"/>	Poor Circulation & Cold Feet
		<input type="checkbox"/>	<input type="checkbox"/>	Impotency	<input type="checkbox"/>	<input type="checkbox"/>	Knee, Ankle & Foot Pain
		<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	Weak Ankles & Arches
		<input type="checkbox"/>	<input type="checkbox"/>	Tailbone Pain	<input type="checkbox"/>	<input type="checkbox"/>	Lower Back Pain

## CONSENT TO CHIROPRACTIC TREATMENT

It is important for you to consider the benefits, risks and alternatives to the treatment options offered by your chiropractor and to make an informed decision about proceeding with treatment.

Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body, soft-tissue techniques such as massage, and other forms of therapy including, but not limited to, electrical or light therapy and exercise.

### Benefits

Chiropractic treatment has been demonstrated to be effective for complaints of the neck, back and other areas of the body caused by nerves, muscles, joints and related tissues. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility, improve function, and reduce or eliminate the need for drugs or surgery.

### Risks

The risks associated with the chiropractic treatment vary according to each patient's condition as well as the location and type of treatment.

The risks include:

- **Temporary worsening of symptoms** – Usually, any increase in pre-existing symptoms of pain or stiffness with only last a few hours to a few days.
- **Skin irritation or burn** – Skin irritation or a burn may occur in association with the use of some types of electrical or light therapy. Skin irritation should resolve quickly. A burn may leave a permanent scar.
- **Sprain or strain** - Typically, a muscle or ligament sprain or strain will resolve itself within a few days or weeks with some rest, protection of the area affected and other minor care.
- **Rib fracture** – While a rib fracture is painful and can limit your activity for a period of time, it will generally heal on its own over a period of several weeks without further treatment or surgical intervention.
- **Injury or aggravation of a disc** - Over the course of a lifetime, spinal discs may degenerate or become damaged. A disc can degenerate with aging, while disc damage can occur with common daily activities such as bending or lifting. Patients who already have a degenerated or damaged disc may or may not have symptoms. They may not know they have a problem with a disc. They also may not know their disc condition is worsening because they only experience back or neck problems once in a while.

Chiropractic treatment should not damage a disc that is not already degenerated or damaged, but if there is a pre-existing disc condition, chiropractic treatment, like many common daily activities, may aggravate the disc condition.

The consequences of disc injury or aggravating a pre-existing disc condition will vary with each patient. In the most severe cases, patient symptoms may include impaired back or neck mobility, radiating pain and numbness into the legs or arms, impaired bowel or bladder function, or impaired leg or arm function. Surgery may be needed.

- **Stroke** – Blood flows to the brain through two sets of arteries passing through the neck. These arteries may become weakened and damaged, either over time through aging or disease, or as a result of injury. A blood clot may form in a damaged artery. All or part of the clot may break off and travel up the artery to the brain where it can interrupt blood flow and cause a stroke.

Many common activities of daily living involving ordinary neck movements have been associated with stroke resulting from damage to an artery in the neck, or a clot that already existed in the artery breaking off and travelling up to the brain.

Chiropractic treatment has been associated with stroke. However, that association occurs very infrequently, and may be explained because an artery was already damaged and the patient was progressing toward a stroke when the patient consulted the chiropractor. Present medical and scientific evidence does not establish that chiropractic treatment causes either damage to an artery or stroke.

The consequences of a stroke can be very serious, including significant impairment of vision, speech, balance and brain function, as well as paralysis or death.

**Alternatives**

Alternatives to chiropractic treatment may include consulting other health professionals. Your chiropractor may also prescribe rest without treatment, or exercise with or without treatment.

**Questions or Concerns**

You are encouraged to ask questions at any time regarding your assessment and treatment. Bring any concerns you have to the chiropractor's attention. If you are not comfortable, you may stop treatment at any time.

**Please be involved in and responsible for your care. Inform your chiropractor immediately of any change in your condition.**

**DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE CHIROPRACTOR**

I hereby acknowledge that I have discussed with the chiropractor the assessment of my condition and the treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I hereby consent to chiropractic treatment as proposed to me.

\_\_\_\_\_  
Name (Please Print)

\_\_\_\_\_  
Signature of patient (or legal guardian)

Date: \_\_\_\_\_ 20\_\_\_\_

\_\_\_\_\_  
Signature of Chiropractor

Date: \_\_\_\_\_ 20\_\_\_\_