Pregnancy Patient Questionnaire

CONFIDENTIAL PATIENT INFORMATION

First Name:	Last Name:	DOB:
Marital Status:	# of children:	Occupation:
Street Address:		
City:	State:	Zip Code:
Email:	Cell Phone:	
Emergency Contact:	Relation:	Phone:
How Did you hear about us?		
Date & Reason for last doctor visit?		
Are you receiving care from any health care providers? ☐ Yes ☐ No		
-if yes, please name them & their specialty		

TOP 3 HEALTH GOALS FOR THIS PREGNANCY AND BIRTH

1.
2.
3.

PREVIOUS BIRTH EXPERIENCE

Is this your first pregnancy? ☐ Yes ☐ No

If not, please tell us about your pevious pregnancy(s):

_____

_____

Do you plan to follow the same plan as your previous delivery? ☐ Yes ☐ No

If not, what would you like to change?

_____

_____

Abundant Life CHIROPRACTIC

CONCEPTION & EARLY PREGNANCY

When is your expected due date? / / How many weeks pregnant are you?

Did you have difficulty conceiving? ☐ Yes ☐ No
If yes, please explain:

What is you pre-pregnancy weight? Lbs Current Weight? Lbs

CURRENT HEALTH CONDITIONS

What health conditions bring you into our office?

Have you received care for this problem before? ☐ Yes ☐ No

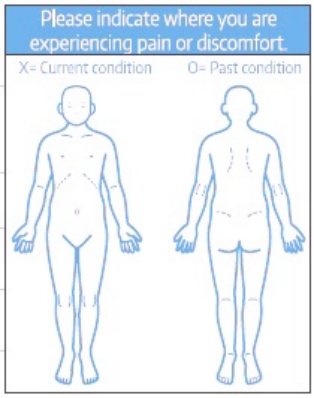
When did the condition(s) first begin?

What type of exercise are you currently performing?

Please tell us about your current diet/any dietary restrictions:

Have you taken any medications or supplements during your pregnancy? ☐ Yes ☐ No
If yes, please explain:

Have you had any slips, falls ot other physical traumas during the pregnancy? ☐ Yes ☐ No
If yes, please explain:



YOUR BIRTH PLAN

Do you currently have a birth plan? ☐ Yes ☐ No
If yes, please explain:

Are you taking any prenatal or birthing classes? ☐ Yes ☐ No
If yes, please explain:

Who is your OB/GYN or midwife? Will they be present for delivery? ☐ Yes ☐ No

Do you intend to have a doula or birth coach present? ☐ Yes ☐ No
If yes, please explain:

Do you wish to have a natural vaginal labor and delivery? ☐ Yes ☐ No
If not, what concerns do you have:

YOUR POST BIRTH PLAN

Do you plan to breastfeed your baby? ☐ Yes ☐ No

What do you intend to do for vaccines?

_____

Is there anything else you'd like to tell us about your pregnancy or birth plan?

_____

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

_____

Do you have any additional questions?

CHIROPRACTIC HISTORY

What would you like to gain from chiropractic care? ☐ Resolve existing condition(s) ☐ Overall Wellness ☐ Both

Have you ever visited a chiropractor? ☐ Yes ☐ No

If yes, what is their name?

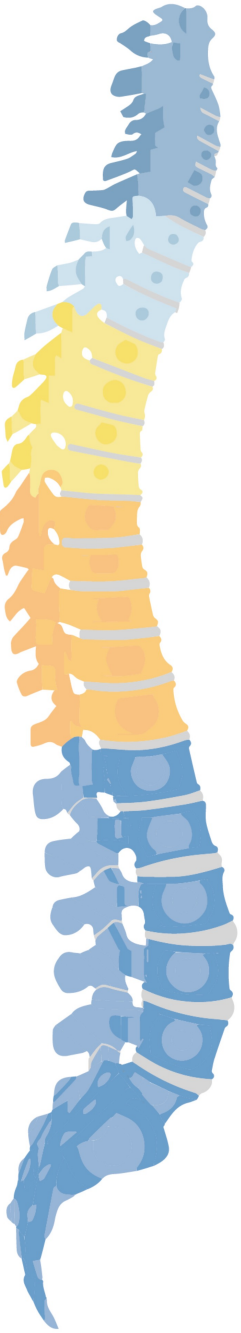
What is their specialty? ☐ Pain Relief ☐ Physical Therapy & Rehab ☐ Nutritional ☐ Subluxation Based ☐ Other

When was your last adjustment?

How often were you getting adjusted

Patient Review of Symptoms

THE NERVOUS SYSTEM CONTROLS & COORDINATES ALL ORGANS AND STRUCTURES OF THE HUMAN BODY



CERVICAL

FUNCTIONS

- Autonomic Nervous System
- ENT System
- Vision, Balance & Coordination
- Speech
- Immune System
- Digestive System
- Nerve Supply to Shoulders, Arms & Hands
- Sympathetic Nucleus
- Metabolism

SYMPTOMS

- ☐ Colic & Excessive Crying
- ☐ Ear & Sinus Infections
- ☐ Allergies & Congestion
- ☐ Immune Deficiency
- ☐ Headaches & Migraines
- ☐ Vertigo & Dizziness
- ☐ Sore Throat & Strep
- ☐ Swollen Tonsils & Adenoids
- ☐ Vision & Hearing Issues
- ☐ Low Energy & Fatigue
- ☐ Difficulty Sleeping
- ☐ Pain, Numbness & Tingling in Arms to Hands
- ☐ Epilepsy & Seizures
- ☐ Sensory & Spectrum
- ☐ ADD / ADHD
- ☐ Focus & Memory Issues
- ☐ Anxiety & Stress
- ☐ Balance & Coordination
- ☐ Speech Issues
- ☐ TMJ / Jaw Pain
- ☐ Stiff Neck & Shoulders
- ☐ Depression
- ☐ High Blood Pressure
- ☐ Poor Metabolism & Weight Control

UPPER THORACIC

FUNCTIONS

- Upper G.I.
- Respiratory System
- Cardiac Function

SYMPTOMS

- ☐ Reflux / GERD
- ☐ Chronic Colds & Cough
- ☐ Asthma
- ☐ Bronchitis & Pneumonia
- ☐ Functional Heart Conditions

MID THORACIC

FUNCTIONS

- Major Digestive Center
- Detox & Immunity

SYMPTOMS

- ☐ Gallbladder Pain / Issues
- ☐ Jaundice
- ☐ Fever
- ☐ Indigestion & Heartburn
- ☐ Stomach Pains & Ulcers
- ☐ Blood Sugar Problems

LOWER THORACIC

FUNCTIONS

- Stress Response
- Filtration & Elimination
- Gut & Digestion
- Hormonal Control

SYMPTOMS

- ☐ Behavior Issues
- ☐ Hyperactivity
- ☐ Chronic Fatigue
- ☐ Chronic Stress
- ☐ Allergies & Eczema
- ☐ Skin Conditions / Rash
- ☐ Kidney Problems
- ☐ Gas Pain & Bloating

LUMBAR

FUNCTIONS

- Lower G.I. (Absorption & Motility)
- Gut-Immune System
- Major Hormonal Control

SYMPTOMS

- ☐ Constipation
- ☐ Chrohn's, Colitis & IBS
- ☐ Diarrhea
- ☐ Bed-wetting
- ☐ Bladder & Urination Issues
- ☐ Cramps & Menstrual Issues
- ☐ Cysts & Endometriosis
- ☐ Infertility
- ☐ Impotency
- ☐ Hemorrhoids
- ☐ Sciatica & Radiating Pain
- ☐ Lumbopelvic / SI Joint Pain
- ☐ Hamstring Tightness
- ☐ Disc Degeneration
- ☐ Leg Weakness & Cramps
- ☐ Poor Circulation & Cold Feet
- ☐ Knee, Ankle & Foot Pain
- ☐ Weak Ankles & Arches
- ☐ Lower Back Pain
- ☐ Gluten & Casein Intolerance

Informed Consent for Chiropractic Care

I hereby request and consent to the performance of chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working with, or associated with or serving as back-up for the doctor of chiropractic named below, including those working at other Chiropractic Partners offices.

I have had an opportunity to discuss with the doctor of chiropractic named below, and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. I understand and am informed that, as with the practice of medicine chiropractic carries some risks to treatment, including, but not limited to fractures, disc injuries, strokes, dislocations and sprains.

I do not expect the doctor to be able to anticipate and explain all risks and complications. I consent to rely on the doctor's best judgment, exercised during the course of treatment that is in my best interest, based upon the known facts. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its consent, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present conditions(s) and for any future condition(s) for which I seek treatment.

_____ _____

Patient Name (Printed) Date Signed

_____ _____

Signature: Patient or Legal Representative (Attorney, Guardian, Parent) Witness to Signature

_____ _____

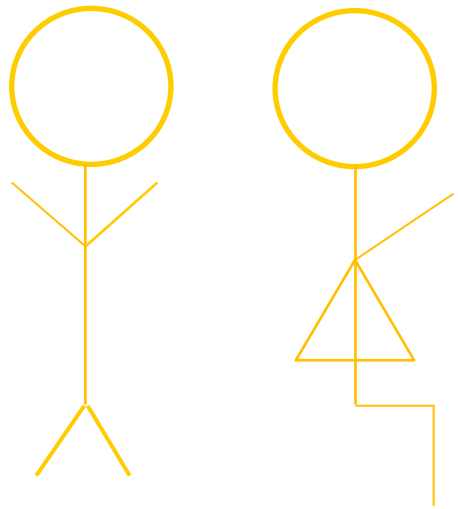
Doctor of Chiropractic Signature Date Signed

Doctor's Use Only

PAST PREGNANCY/BIRTHS

NOTES

WKS PREGNANT:



KIDS:

PRIOR DC: Y / N

GOALS

PAST SURGERIES/INJURIES/MEDS