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

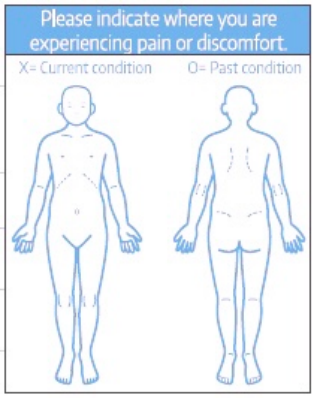
When did the condition(s) first begin?

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 or 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?

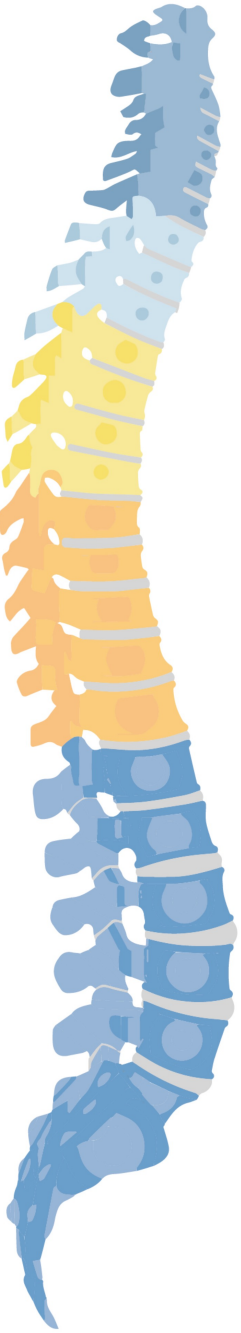
What is their specialty? ☐ Pain Relief ☐ Physical Therapy & Rehab ☐ Nutritional ☐ Subluxation Based ☐ Other

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.

Photo Consent

I hereby authorize Abundant Life Chiropractic to use my testimonial and any information contained herein, including photos and video, in its public relation efforts. I understand and approve the disclosure of testimonial information, photos and video to the media, social media and other individuals and entities that may be involved in the public relations efforts of Abundant Life Chiropractic, including but not limited to Abundant Life Chiropractic's Facebook page, Instagram page, and in-office displays. By signing below I agree and acknowledge that I have read and understood the above and Release, have had the opportunity to ask questions about it, and agree to all terms described.

☐ Yes, I give consent to take and use photos ☐ No, I do not give consent for photos

_____ _____

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

WKS PREGNANT:_____
Gender: _____

ROF:

KIDS:_____

PRIOR DC: Y / N

NOTES

GOALS

PAST SURGERIES/INJURIES/MEDS