Donohoe Chiropractic

Client Information for Pre- and Post-Natal Clients

In order to provide you the best wellness care, please complete this form in it's entirety.
All information is strictly CONFIDENTIAL.

Name _____Today's Date _____

Address _____ City _____ State _____ Zip_____

Home Phone _____ Cell Phone _____

Email _____

(Your email will NOT be shared with any 3rd parties, and is used for general office announcements and promotions. We won't spam you.)

Date of Birth _____Age_____

Week of Pregnancy _____ Expected Due Date _____

Emergency contact

Name _____ Relationship _____

Home Phone _____Cell Phone _____

Account Information

Person Ultimately Responsible for this account.

Name: _____ Relation: _____

Billing Address: _____ City: _____

State: _____ Zip: _____ Home Phone: _____

Driver's License # _____ Social Security # _____

Payment Method: □ Cash □ Check □ Credit Card _____ (Type)

_____ Credit Card Number

____/____/_____ Expiration Date

I understand that outstanding balances of more than 30 days will be charged to this account. _____ Initials

Physician or Midwife _____ Doula (if applicable) _____

____ multiple pregnancy (twins)
____ gestational diabetes
____ placental dysfunction
____ high blood pressure
____ pre-eclampsia
____ threatened miscarriage
____ premature labor
____ heart disease
____ bladder infection
____ swollen hands or feet
____ varicose veins
____ phlebitis
____ leg cramps
____ restless legs
____ headaches
____ headaches
____ heartburn
____ constipation
____ hemorrhoids
____ difficulty sleeping

In which areas of your body are you currently experiencing tension, discomfort, or pain?

_____
_____
_____

Are there any areas where you would like me to focus during your massage session? Is there anything else you would like me to know about your health or pregnancy?

_____
_____
_____

Are there any areas where you would prefer not to receive massage today?

_____

I generally prefer: _____ music without words
_____ music with words
_____ no music
_____ no preference

When I receive massage, I usually prefer:

_____ to chat with the therapist
_____ to be spoken to only to check in about pressure and comfort level
_____ almost complete silence

_____ _____

Client Signature Date

DONOHOE CHIROPRACTIC | 41880 Kalmia Street Suite 135 | Murrieta, CA 92562
Phone 951.677.6500 | Fax 951.677.2665 | www.DonohoeChiropractic.com