Miladin Chiropractic

PREGNANCY HISTORY FORM

First Name: _____ Middle: _____ Last: _____

Street Address: _____ City: _____

State: _____ Zip: _____ Mobile Phone: _____

Work Phone: _____ Home Phone: _____

Email Address: _____ SS#:_____

Date of Birth: ___/____/____ Gender: ☐M ☐F

Height: _____ Weight: _____

Marital Status: ☐ Single ☐Married ☐Separated ☐Divorced ☐Widowed ☐Other

Number of Children: _____

Spouse's Name: _____

Emergency Contact Information:

Name: _____

Phone: _____

Relation to You: _____

Referral Information:

How did you hear about us?

☐Word of Mouth ☐Advertisement ☐Social Media ☐Direct marketing ☐Google

Referring Physician Phone: _____

Referring Patient: _____

Are you working with an Attorney? : ☐Y ☐ N

Employer: ☐ Full time ☐Part Time ☐Unemployed ☐Full Time Student

Employer Name: _____ Address: _____ City: _____

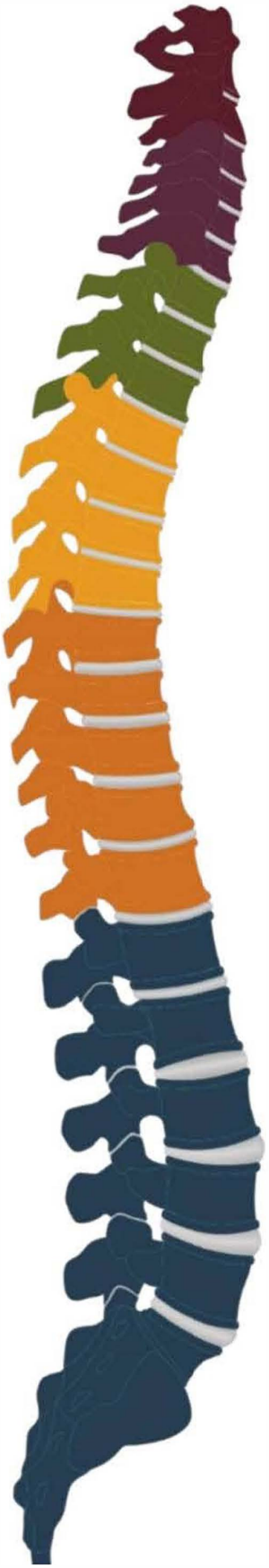
State: _____ Zip: _____ Supervisor: _____ Phone: _____

Work Duties: _____

Patient Review of Systems

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

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



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

Pregnancy Questionnaire

Previous Birth Experience:

Is this your first pregnancy? ☐Y ☐N

Do you plan to follow the same plan as your previous delivery? ☐Y ☐N

If no, what would you like to change? _____

Conception & Early Pregnancy

When is your expected or calculated due date? _____

Did you have any difficulty conceiving? ☐Y ☐N

If yes, please explain _____

Current Health Conditions

What type of exercise(s) are you currently preforming? _____

Please tell us about your current diet, and any dietary restrictions _____

Have you take any medications or supplements during pregnancy? ☐Y ☐N

If yes, please list: _____

Have you had any slips, falls, or other physical traumas during pregnancy? ☐Y ☐N

If yes, please explain: _____

Have you had any major emotional stressors during pregnancy? ☐Y ☐N

If yes, please explain: _____

INFORMED CONSENT TO TREATMENT

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Patient Signature: _____

Date: ____/____/____