Post Natal Health Questionnaire

Congratulations on your new bundle of joy!

Your Name:_____

Baby's Name:_____ Baby's D.O.B._____Gender:_____

Please check all that apply:

- ☐ Born on due date
- ☐ Went into labor naturally
- ☐ Medically induced labor
- ☐ Water broke naturally
- ☐ Water broken by doctor
- ☐ Vaginal Birth
- ☐ VBAC
- ☐ Scheduled cesarean
- ☐ Epidural used
- ☐ Forceps Used
- ☐ Vacuum extraction used
- ☐ Umbilical cord was around the neck of the baby
- ☐ Nursing currently
- ☐ Pumping currently
- ☐ Formula only currently
- ☐ Both breast milk and formula
- ☐ Baby up to date on vaccines
- ☐ Modified / delayed vaccine schedule
- ☐ Religious vaccine exemption
- ☐ Medical vaccine exemption

If born early, how early?_____

If born late, how late?_____

Approximately how long did you push?_____

If Emergency Cesarean, what was the reason?_____

_____

If Planned Cesarean, what was the reason?_____

_____

Any issues with the baby's health?_____

_____

How are you feeling physically?_____

_____

How are you feeling mentally?_____

Interested in more information on any of the following?:

- ☐ Chiropractic care for infants & toddlers
- ☐ Baby wearing
- ☐ Cloth diapers
- ☐ Lactation consultant
- ☐ Meal planning
- ☐ Postpartum emotional wellness
- ☐ Pelvic floor physical therapy
- ☐ Postpartum doula

Signature:_____ Today's Date:_____

Patient Introduction Card

Today's Date _____ Account #_____

Full Legal Name _____ Prefer To Be Called_____

Home Address_____ Occupation_____

City_____ State_____ Zip_____ Employer_____

Home Phone_____ Name of Insurance Co_____

Cell Phone_____ Policy Holder Name _____

Work Phone_____ Policy Holder Date of Birth _____

Email_____ Primary Care Doctor_____

Date of Birth_____ Age_____ Previous Chiropractic Care? ☐ YES ☐ NO

☐ Married ☐ Single ☐ Other_____ Major Complaint Today_____

Preferred method of contact for appointment reminders ☐ Text ☐ Email ☐ Either is fine

Who (or what source) referred you to our office? _____

It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged

Patient Health Questionnaire

Patient Name_____ **Date**_____

1. What are your current symptoms (List the worst one first):

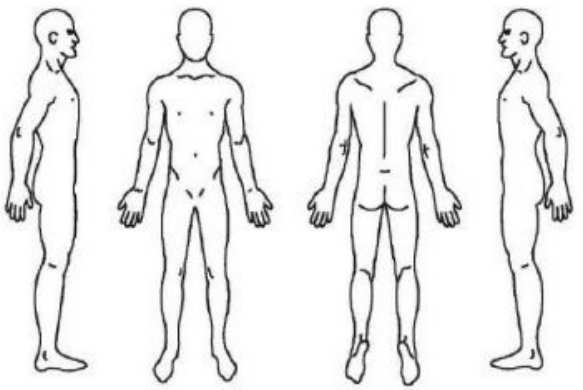
_____

_____

_____

_____

INDICATE WHERE YOU HAVE PAIN



2. How long have you had your main symptom?

This episode: _____

First episode EVER: _____

3. How often are your symptoms present? □ Occasional (0-25%) □ Frequent (50-75%) □ Intermittent (25-50%) □ Constant (75-100%)

4. What do you feel caused your symptoms? □ Car Accident □ Fall □ Sports Injury □ Lifting □ Work □ Posture □ Other_____

5 What have you tried for your current complaint?

□ Nothing	□ Advil / Tylenol / Aleve (CIRCLE)	□ Chiropractic Care	□ Yoga
□ Prescription Pain Meds	□ Injections	□ Acupuncture	□ CBD
□ Muscle Relaxer	□ Massage Therapy	□ Physical Therapy	□ New Mattress / Pillow (CIRCLE)
□ Ice / Heat (CIRCLE)	□ Foam roller	□ Stretching	□ _____

6. Who else have you seen for your current symptoms?

□ No One	□ Medical Doctor / PCP	□ Neurologist	□ Acupuncturist
□ This Office	□ OBGYN / Midwife	□ Physical Therapist	□ OTHER _____
□ Other Chiropractor	□ Orthopedic Doctor	□ Massage Therapist	

7. What tests have you had for your symptoms? □ None □ MRI date: _____ □ X-rays date :_____ □ CT Scan date: _____

8. What activities make your symptoms better? □ Ice □ Rest □ Sitting □ Medication □ Heat □ Activity □ Standing □ _____

9. What activities make your symptoms worse? □ Ice □ Rest □ Sitting □ Getting Dressed □ Heat □ Activity □ Standing □ _____

10. What describes the nature of your symptoms?

□ Dull	□ Aching	□ Numb	□ Burning	□ Tight / Stiff
□ Sharp with movement		□ Shooting	□ Tingling	□ Sore

11. Do your symptoms radiate (travel)? □ Yes □ No If yes, to what part of your body? _____

12. What is the severity of your symptoms (CIRCLE the range)? **0 1 2 3 4 5 6 7 8 9 10**

13.What activities are affected by your symptoms?

□ Work/School (CIRCLE)	□ Exercise	□ Driving/Riding in Car (CIRCLE)	□ House Work	□ Mood
□ Getting dressed	□ Running	□ Caring for Children	□ Yard Work	□ Focus
□ Sleeping	□ Walking	□ Going up / down stairs	□ Bathing	□ _____

14. Have your symptoms been getting... □ Better □ Worse □ Staying the same

Please check any condition below that you had in the past or have currently...

16. PAST	17. PRESENT		16. PAST	17. PRESENT		16. PAST	17. PRESENT	
□	□	Migraines	□	□	Dizziness	□	□	Asthma
□	□	Headaches	□	□	Nausea	□	□	Chronic Sinusitis
□	□	Neck Pain	□	□	High Blood Pressure	□	□	Seasonal Allergies
□	□	Upper Back Pain	□	□	Low Blood Pressure	□	□	Diabetes
□	□	Mid Back Pain	□	□	High Cholesterol	□	□	Excessive Urination
□	□	Low Back Pain	□	□	Heart Attack	□	□	Excessive Thirst
□	□	Scoliosis	□	□	Chest Pains	□	□	Hypo-Thyroid
□	□	Shoulder Pain	□	□	Stroke	□	□	Hyper-Thyroid
□	□	Elbow Pain	□	□	Angina	□	□	Smoking/ Tobacco Use
□	□	Wrist Pain	□	□	Kidney Stones	□	□	Drug/ Opioid Dependence
□	□	Hand Pain	□	□	Kidney Disorder	□	□	Alcohol Dependence
□	□	Carpal Tunnel	□	□	Bladder Infection	□	□	Food Allergies
□	□	Hip Pain	□	□	Painful Urination	□	□	Depression
□	□	Knee Pain	□	□	Loss of Bladder Control	□	□	Anxiety
□	□	Ankle Pain	□	□	Prostate Problems	□	□	Frequent Illness
□	□	Foot Pain	□	□	Reflux/Heartburn	□	□	Epilepsy
□	□	Sciatica	□	□	Abnormal Weight Gain	□	□	Dermatitis
□	□	Jaw Pain/TMJ	□	□	Abnormal Weight Loss	□	□	Eczema
□	□	Osteopenia	□	□	Loss of Appetite	□	□	Poison Ivy/ Oak
□	□	Osteoporosis	□	□	Constipation			
□	□	Joint Swelling/Stiffness	□	□	Abdominal Pain	***Females Only***		
□	□	Ehlers-Danlos Syndrome	□	□	Ulcer	□	□	Hot Flashes
□	□	Arthritis	□	□	HIV/ AIDS	□	□	Hormone Replacement
□	□	Rheumatoid Arthritis	□	□	Hepatitis	□	□	Birth Control Pills
□	□	Lyme Disease	□	□	Liver Disorder	□	□	Painful Periods/Cramps
□	□	General Fatigue	□	□	Gall Bladder Disorder			
□	□	Ringing In Ears	□	□	Cancer	YES	NO	Are You Pregnant?
□	□	Visual Disturbances	□	□	Tumor			

18. Primary Care Physician_____ **18b. Date of Last Medical Physical**_____

19. Indicate if an immediate family member has had any of the following:

□ Rheumatoid Arthritis □ Heart Problems □ Diabetes □ Cancer □ Lupus □ Other: _____

20. List all prescription and over-the-counter medications, nutritional/herbal supplements, essential oils, or CBD you are taking:

_____

21. List all the surgical procedures you have had AND times you have been hospitalized (INLCUDING GIVING BIRTH):

_____

_____

22. ANY & ALL LIFETIME TRAUMA HISTORY, EVEN IF YOU DID NOT HAVE SYMPTOMS OR TREATMENT:

Auto Accidents:_____

Falls: _____

Sports Injuries:_____

Concussions:_____

Other Physical Traumas: _____

23. Age of Mattress:_____ years Sleep Position: □ back □ side □ stomach # of pillows under your head?_____

PATIENT SIGNATURE:_____ **Date:**_____