POSITIVELY CHIROPRACTIC

Please fill out this additional form related to your upcoming pregnancy. Both Dr. Erin and Dr. Sarah have extra certifications in pregnancy and pediatric chiropractic care, so you are in very good, skilled hands here!

Describe Positive Lifestyle Habits you participate in:

Exercise Regularly? Yes No Explain: _____

Eat a balanced diet? Yes No Explain: _____

Sleep 8 hours a day? Yes No Explain: _____

Reason for visit beyond preventative care and health maintenance:

Have you ever been to a Chiropractor before? _____ D.C.'s Name: _____

Who is your Midwife or Ob/Gyn _____ Phone #: _____

The reason for this visit is a result of (please circle):

Wellness/Breech presentation/Backache of pregnancy/ Headache/Trauma/Chronic condition/ Other:

_____

How many pregnancies have you had?_____ Vaginal Delivery_____ Cesarean Section _____

Please explain any complications with this or past pregnancies

_____

_____

Are you taking any medications and/or vitamins? Yes No If yes, please explain

_____

_____

Have you ever suffered from (please circle):

Dizziness:	Before Pregnancy	During Pregnancy
Backaches:	Before Pregnancy	During Pregnancy
Water Retention:	Before Pregnancy	During Pregnancy
Diabetes:	Before Pregnancy	During Pregnancy
High Blood Pressure:	Before Pregnancy	During Pregnancy
Headaches:	Before Pregnancy	During Pregnancy
Asthma:	Before Pregnancy	During Pregnancy
Stomach Trouble:	Before Pregnancy	During Pregnancy
Nervousness:	Before Pregnancy	During Pregnancy
Sinus Trouble:	Before Pregnancy	During Pregnancy
Neck Pain:	Before Pregnancy	During Pregnancy

Other:

_____

_____

How many weeks gestation is your baby? _____

When is your due date? _____

Welcome to **Positively Chiropractic**. Our mission is to restore and maximize health for all families and individuals in our community. Please take a few moments to completely fill out this form. We will take GREAT care of you here!

First Name: _____ MI: _____ Last Name: _____Date:_____ Address:_____
City:_____ State:_____ Zip:_____
Phone Numbers:(home)_____ (cell)_____
Email:_____
Date of Birth:___/_____/_____ Age:_____ SSN:_____ Sex: M F
Marital Status: S M D W O Name of Spouse/Partner:_____ Names and Ages of Children:_____ Are you pregnant? Yes No
Occupation:_____ Employed by:_____ Where did you hear about our office?_____ If referred, whom may we thank: _____

Reason(s) for seeking care: *Please briefly describe the area of chief complaint(s).*
*********If you have no complaints, and are seeking chiropractic care for wellness, indicate "none" below.*
Intensity Scale 0=none, 10=unbearable
1. _____ for how long _____ **0 1 2 3 4 5 6 7 8 9 10**
2. _____ for how long _____ **0 1 2 3 4 5 6 7 8 9 10**
3. _____ for how long _____ **0 1 2 3 4 5 6 7 8 9 10**

Based on your primary complaint:
How did your complaint begin?
_____
What is the character of your pain/symptoms (sharp, achy, dull, etc.)?
_____
What makes it worse? _____ Better?
_____
Do your symptoms stay in the same place or do they radiate/travel? Describe:
_____
How often is it present? □ Intermittent (<50%) □ Frequent (51-75%) □ Constant (>75%)
Since your problem began, is it? □ Getting better □ Staying the same □ Getting worse
Who else have you seen for this? □ None □Chiropractor □ MD □ Other When?
_____
Please describe how your health concerns are affecting your life:_____

Current and past body signals underlying dysfunction
Please indicate which of the following body signals you have experienced or are currently experiencing:

□ Fainting	□ Prostate trouble	□ Stroke	□ Scoliosis
□ Shortness of breath	□ Bed wetting	□ Jaw pain/TMJ	□ Pain in legs/feet
□ High blood pressure	□ Cancer	□ Heart Attack	□ Numbness in legs/feet
□ Fatigue	□ Kidney problems	□ Indigestion	□ Pins/Needles in legs
□ Loss of Balance	□ Diabetes	□ Gall Bladder trouble	□ Swollen ankles
□ Memory loss	□ Headaches	□ Constipation	□ Cold feet/hands
□ Depression	□ Sinus trouble	□ Allergies	□ Neck Pain
□ Nervousness	□ Ringing in the ears	□ Asthma	□ Shoulder/Arm pain
□ Thyroid trouble	□ Blurred vision	□ Swollen joints	□ Shoulder/Arm tightness
□ Seizures	□ Ear infections	□ Arthritis	□ Pins/Needles in arm/hanc
□ Anemia	□ Loss of smell	□ Low back pain	□ Mid-Back Pain
□ Menstrual problems	□ Ulcers	□ Hip pain	□ Other

Stress that occurs in our lifetime impacts our health. It is important for us to understand the physical, chemical and emotional stresses you have endured over time in order to better take care of you. Please describe the following:

Physical

Did your birth include the following? □Cesarean □ Vacuum/Forceps □ Vaginal □ Unknown
Describe your typical work setting? □ Sitting □ Standing □Walking □ Lifting
Have you experienced the following? □ Falls □ Surgeries □ Fractures/Injuries
Have you been involved in any auto accidents? Yes No
Describe_____
Describe your sleep patterns? □ Side □ Back □ Stomach
Duration: □ <4hrs □ 5-8 □ 8+hrs

Chemical

Have you been vaccinated as a child or an adult? Yes No Last one received?
_____
Bad reactions?_____
Do you? □ Smoke tobacco □ Use recreational drugs □ Drink alcohol
Do you consume? □ Fried foods □ Soda/Pop □ Dairy □ Caffeine □ Sweeteners
Do you take any prescription or non-prescription drugs?
1._____Reason:_____
_____
2._____Reason:_____
_____
3._____Reason:_____
_____

Emotional

Do you consider yourself? □ Overstressed □ Lonely □ Unfortunate
Have you experienced? □ Loss of a loved one □ Divorce □ Loss of a job How recent_____
Rate your job satisfaction (low) **0 1 2 3 4 5 6 7 8 9 10** (high)
Rate your personal fulfillment (low) **0 1 2 3 4 5 6 7 8 9 10** (high)

Describe positive lifestyle habits you participate in.

Physical: ☐ Cardiovascular exercise ☐ Strength training ☐ Swimming ☐ Biking ☐ Yoga/Pilates
☐ Other: _____ How often:_____
Chemical: ☐ Organic foods ☐ Vitamins/supplements ☐ Use of non-chemical cleaners
Emotional: ☐ Spiritual/meditation ☐ Counseling ☐ Support groups

How important is finding the cause of your health concerns? (low) **1 2 3 4 5 6 7 8 9 10** (high)
How important is the quality of your life? (low) **1 2 3 4 5 6 7 8 9 10** (high)

What are your goals for care? ☐ Remove pain ☐ Restore health ☐ Full health potential

Why?_____
_____

I agree to assume responsibility for any charges created by my chiropractic care, and give consent to be examined and/or treated by the doctors and staff of Positively Chiropractic.

Patient Signature:
_____Date:_____