West Valley Chiropractic Centre

Pregnancy History

Name: ______________________ Occupation: ______________________
Address: ______________________ Marital status: ______________________
City: __________ Prov: ______ PC: ______ Spouse's name: ______________________
Phone: (H) __________ Other: __________ No. of children: __________ Due date: ______
E-mail: ______________________ AB health care #: ______________________
Date of birth: ______________________ Referred by: ______________________

Chiropractic History

Have you previously been to a chiropractor? __________ Did they take x-rays? __________
Reason? ______________________
If yes, when was your last visit and how long did you receive care? ______________________

Current Health Condidtion ☐ I'm here for wellness and have no complaints (please skip to the next section)

Reason for today's visit? ______________________
The pain or problem started on: __________ What happened? __________
Pain is: ☐ Sharp ☐ Dull ☐ Constant ☐ Intermittent ☐ Other __________
Pain is interfering with: ☐ Work ☐ Sleep ☐ Routine ☐ Other __________
What activities aggravate your condition? ______________________
What activities lessen your condition? ______________________
Is it worse during certain times of the day? __________ Is it getting progressively worse? __________
Other Doctors seen: __________ Any home remedies? __________

Other Symptoms:

	☐ Pins & needles in legs	☐ Fever	☐ Constipation	Other conditions,
☐ Headaches	☐ Pins & needles in arms	☐ Fainting	☐ Loss of balance	diseases or concerns:
☐ Neck pain/stiff	☐ Numbness in fingers	☐ Cold sweats	☐ Ear Infections	__________
☐ Sleeping problems	☐ Numbness in toes	☐ Loss of smell	☐ Asthma	__________
☐ Back pain	☐ Shortness of breath	☐ Loss of taste	☐ Allergies	__________
☐ Nervousness	☐ Fatigue	☐ Difficulty swallowing	☐ Frequent colds/flu	__________
☐ Tension	☐ Depression	☐ Diarrhea	☐ Thigh pain	__________
☐ Irritability	☐ Light Bothers Eyes	☐ Feet cold	☐ Pubic pain	__________
☐ Chest Pains	☐ Double Vision	☐ Hands cold	☐ Leg/calf cramps	__________
☐ Dizziness	☐ Loss Of Memory	☐ Stomach upset	☐ Multiple Sclerosis	__________
☐ Face Flushed	☐ Ears Ring/Buzzing	☐ Nausea	☐ IBS/Crohn's disease	__________

Birthing Information

Who are your chosen birth attendants? ☐ Midwife ☐ Obstetrician ☐ Doula ☐ Chiropractor
Name of birth attendants: __________ Date of last visit: __________
Chosen location of birth: ☐ Hospital ☐ Birthing Center ☐ Home
How active is your baby? ☐ Not moving at all ☐ slow but moving ☐ active ☐ very active ☐ other
If you have had a previous pregnancy did you have or experience any of the following with your labour:

☐ Hospital birth	☐ Induction	☐ Fetal scalp monitoring	☐ C-Section
☐ Home birth	☐ Epidural	☐ Back labour	
☐ Birthing centre birth	☐ Episiotomy	☐ Forceps	
☐ Other birth location	☐ Breech presentation	☐ Vacuum extraction	

Accidents/trauma/Injury History

Number of car accidents: __________ Approximate dates: __________
Any work, sports or other injuries: ______________________
Any medications you are currently taking & for what conditions: ______________________
Have you had surgery? ☐ Yes ☐ No If yes, what type? __________
Any significant family medical conditions/history: ______________________
Rate your occupational stress (1-10 with 10 being the most stressful) __________ Date of maternity leave: __________

As a result of my chiropractic care, I would like to: (please check all that apply)

☐ Feel better quickly	☐ Have a healthier spine and postural alignment
☐ Imporve function and performance	☐ Prepare my body & pelvis for labour/delivery
☐ Have a better quality of life	☐ Turn breech/posterior baby

Signature: ______________________ Date: ______________________

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