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: _____

INTERNAL USE: E: __ Health Goal: ___ Other: ___ PC:___
Staff Init. _____ Date:_____

Wellness Intake Form

Name: _____ Date: _____ Age: _____

Email Address: _____ Phone: _____

DIETARY INTAKE SUMMARY:

How many servings of fruit do you consume per day? _____
How many servings of vegetables do you consume per day? _____
How many servings of protein do you consume per day? _____
How many servings of bread/crackers/pasta do you consume daily? _____
Do you consume artificial sweeteners? __Yes __ No If yes, what brands? _____
Do you consume fast food? __ Yes __ If yes, what do you typically eat? _____
Do you eat breakfast? __ Yes __ No If no, what time is your first meal of the day? _____
Do you consume alcoholic beverages? __ Yes __ No If yes, how many per week? _____
Do you consume coffee? __ No __ Yes If yes, how many cups per day? _____
Do you consume dietary supplements? __ No __ Yes If yes, please list all of them below. Additionally, please bring them in so we can check for ingredients that are not healthful or may have contraindications with medications.

_____

Please indicate the areas of health that you want to improve:

___ 1.Lose weight ___ 2.More energy ___ 3.Sleep better ___ 4.Improve digestion ___ 5. Allergies ___ 6. Improve bloodwork

___ 7.Immune Support ___ 8.Anti-aging support ___ 9.Improve general health ___ 10.Stress Management

If you could improve ONE THING about your health, what is your priority?

_____

IDENTIFYING YOUR HEALTH GOALS:

To help our office understand your wellness goals and give you the type of care that you want, please use this chart to answer the questions below.

-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5
I have serious concerns about my overall health	I feel worried about my health	I have constant concerns that affect my health	I have health challenges that affect me on a daily basis	I have some minor complaints about my health	I feel okay about my health with no complaints	I feel good most days	I feel well on a daily basis	I feel energetic and healthy	I feel active, energetic and fit	I feel great and am proactive about my health

1. What number best describes how you feel about your health today? _____
2. What health goal do you want to achieve?: _____

NOTE: In our commitment to your health, our office provides our patients with access to a free online resource for education, science and wellness support. We will create your login ID and provide access information. Please indicate which free wellness classes you wish to be informed of:

__ Health Reality Check __ The Meaning of Essential Nutrients __ Creating Optimal Health __ Other _____
__ Customizing Your Health Plan __Healthy Age Management __ Genetics and Health __ Healthy Weight Loss

The Stress Test

PATIENT: _____ **DATE:** _____

Each of us has had stress from birth to the present time and will continue to have stress as long as we are alive. Please circle when you have experienced these various stressors no matter how mild or severe your exposure may have been. Also the number of times, from few to many. Circle as many as apply.

C (child), T (teenager), A (adult) or N (None)

			EXPLAIN
I.	**PHYSICAL STRESS:**		
	Birth Traumas (as a mother or child)	C T A N	_____
	Slips/Falls	C T A N	_____
	Car Accidents	C T A N	_____
	Sports Injuries	C T A N	_____
	Physical Abuse	C T A N	_____
	Work Injuries	C T A N	_____
	Poor Posture	C T A N	_____
	Sitting on your wallet for years	C T A N	_____
	Sleeping Position - Stomach	C T A N	_____
	Extensive Computer Work	C T A N	_____
	Carrying Heavy Purse/Backpack/Child	C T A N	_____
	Repetitive Lifting/Bending	C T A N	_____
	Driving for Many Hours	C T A N	_____
	Continuous Hours Sitting/Standing	C T A N	_____
	Bone Fracture/Surgery	C T A N	_____
II.	**EMOTIONAL STRESS:**		
	Relationships	C T A N	_____
	Career	C T A N	_____
	Children	C T A N	_____
	Money	C T A N	_____
	Fast-Paced Life	C T A N	_____
	Hold in Feelings	C T A N	_____
	Quick Tempered	C T A N	_____
	Verbal Abuse	C T A N	_____
	Perfectionist	C T A N	_____
	Procrastinator	C T A N	_____
	Sickness or Loss of Loved One	C T A N	_____
III.	**CHEMICAL STRESS:**		
	Environment (i.e. pollution)	C T A N	_____
	Smoker or Second Hand Smoke	C T A N	_____
	Poor Diet	C T A N	_____
	Caffeine - Amount?	C T A N	_____
	Excessive Sugar	C T A N	_____
	Artificial Sweeteners	C T A N	_____
	Prescription Drugs	C T A N	_____
	Over-the-counter Drugs (i.e. Tylenol, Motrin)	C T A N	_____

IV. Which do you feel is your primary stress? (Circle) Physical Chemical Emotional

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: ____/____/____