HANDS ON HEALTH
FAMILY CHIROPRACTIC

Welcome to Hands on Health Family Chiropractic!

Please fill out this form completely and accurately, to the best of your ability.
All the information requested below is necessary for us to serve you in the best way possible.

Today's Date: _____

PREGNANCY INTAKE FORM

PERSONAL INFORMATION:

Name_____
Age _____ Gender: Male __ Female __ Date of Birth (dd/mm/yyyy)_____
Home Address_____
City _____ Prov____ Postal Code _____ Cell phone (____) _____
E-mail address _____
Preferred method of contact: ___ Text message ___ Email ___ Phone call
Occupation_____Employer_____
Work Status Full Time Part Time Disability Student Retired Unemployed
Marital Status S M Partner D W Name of Spouse/Partner_____
Whom may we thank for referring you to our office? _____

REASON FOR SEEKING CHIROPRACTIC CARE:

Please describe why you have come to Hands on Health Family Chiropractic today.

_____
_____
_____

What are your three main health goals/concerns (can include any goal from any category - nutrition, exercise, wellness, mental health, lifestyle, sleep, etc)?

_____
_____
_____

HEALTH CARE PRACTITIONER HISTORY:

Previous Chiropractor? __Yes __No Name _____
What City/Town? _____Date of last visit?(mm/yy) _____

Name of Medical Doctor _____
Phone _____Date of last visit? (mm/yy)_____
Other Health Care Professionals: _____

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TRAUMA HISTORY:

Have you ever injured your spine, head, neck, rib/chest area, back, pelvis or hips? ___Yes ___No
Please Explain:_____

Have you ever broken any bones or sprained any part of your body? ___Yes ___No
Please Explain:_____

Have you ever been hospitalized or had any previous surgeries? ___Yes ___No
Please Explain:_____

Do you regularly suffer from or experience any of the following? (Yes=Checkmark No=Leave Blank)							
	Allergies		Gas/Bloating		Headache/Migraine		Thyroid Problems
	Skin Problems		Difficulty digesting food		Difficulty Concentrating		Getting up at night to Urinate
	Flu/Colds		Heartburn		Difficulty Remembering		Asthma
	High Blood Pressure		Constipation		Fatigue		Sinus Problems
	Low Blood Pressure		Increased Urination		Frequently Irritable or Angry		Previous Cancer
	Previous Heart Attack		Decreased Urination		Anxiety		Painful or Irregular Menstruation
	Previous Stroke		Loss of Sleep		Depression		Birth Control Pill/Shot

PRENATAL HISTORY:

Is this your first pregnancy? ___Yes ___No; If 'No', how many other births have you had? _____
How many weeks pregnant are you now? _____
Have you experienced any traumas (accidents, falls) during this pregnancy? ___Yes ___No
Please describe: _____

Any medications taken during this pregnancy? ___Yes ___No; If 'Yes';

_____

_____

Please list all current Supplementation/Vitamins

_____

_____

_____

Have you had any evaluation procedures (ex: ultrasound, amniocentesis)? ___Y ___N
Please list dates, frequency and reason for these procedures:

_____

_____

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Who is your birth care provider?

_____

Will you have someone with you at birth for support (other than birth care provider)? ___Yes ___No
Please specify who:_____
Where do you plan on delivering? _____
Have you put together a birth plan? __Yes __No If Yes ; _____

What type of exercise do you currently partake in?_____
Days per week?_____ Hours at a time?_____
What type would you like to partake in?_____
When was the last time you would consider yourself fit?_____

Water intake per day?_____
Caffeine intake per day?_____ What form?_____
Do you smoke or drink alcohol? ___Y ___N; How much/how often?_____

Sleep: Position?_____ Bedtime?_____
Fall asleep easily?__Yes __No; Stay asleep?__Yes __No; Number of Times Awake at Night _____

Have there been any stressful events in your life during this pregnancy?

_____

What are your most significant fears associated with this birth?

_____

How stressed do you feel on a scale of 0-10

Professional/Job-related?

Stress Free					Moderate					Overwhelmed
0	1	2	3	4	5	6	7	8	9	10

Personal life?

Stress Free					Moderate					Overwhelmed
0	1	2	3	4	5	6	7	8	9	10

PREVIOUS BIRTH HISTORY (if multiple births then mark any and all that apply):

1) Place of birth: ___Hospital ___Birthing Center ___Home
2) Delivering Practitioner: __OB/Gyn __Certified Midwife
3) Position of Delivery: __Lithotomy position (on back with feet up) __On Your Side __Kneeling __Squatting __Other? _____
4) Was labor induced? (Contractions were stimulated *prior* to the natural onset of labor)
___Yes ___ No ___ Unknown
If yes, specify type: ___Pitocin ___Prostagland Gel (applied to your cervix) ___Unknown

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5) Were your membranes ruptured by your care provider? ___Yes ___No ___Unknown
6) Were contractions stimulated intravenously with pitocin *once* labor started? __ Y __ N __Unknown
7) Did you receive any pain medications or anesthesia? ___ Yes ___No ___Unknown
Please specify type used_____
If you had an epidural, how many centimeters were you dilated when it was administered? _____ cm
8) Did you experience back pain during labor? ___Yes ___No ___Unknown
9) Did you deliver vaginally? ___Yes ___No
10) Baby presentation at time of delivery: ___Normal ___Posterior ___Brow ___Facial ___Breech
If breech, specify type: ___Footling ___Frank ___Complete ____Kneeling
Was there any visible injury to your baby? ___Yes ___No ___Unknown
If so, where on your baby was the injury sustained?_____
11) Did your care provider assist delivery with his/her hands? ___Yes ___No ___Unknown
Was there any turning of the neck, or traction (pulling) applied to the neck? ___Yes ___No __Unknown
12) Were operative devices used used to facilitate the birth? ___Yes ___No ___Unknown
Which type? ___Forceps ___Vacuum ___Extraction
If yes, were there any visible signs of injury to your baby? ___Yes ___No ___Unknown
If yes, where was the injury
sustained?_____
13) Was there a birthing coach present? ___Husband ___Doula ___Friend Other?___ _____
14) At what week of pregnancy was your baby born? _____

FINANCIAL INFORMATION

Payment in full is expected on all first visit services. All other fees are to be paid at the time of service unless other arrangements have been made and agreed upon in writing. We accept Visa, Mastercard, Interac, AMEX, Cash or Cheque.

Insurance coverage varies greatly. We cannot predict whether your policy will cover the services we provide in our office. You are responsible for payment of all services at the time of service. We will gladly supply detailed receipts for you to submit to your insurance company for reimbursement.

The information I have provided on this case history form is true and accurate to the best of my knowledge. I give the doctors at Hands on Health Family Chiropractic permission to render care to me today.

Name (Please Print) :_____
Signature_____ Today's Date_____

Thank you for choosing Hands on Health Family Chiropractic.
We look forward to helping you improve your health and well-being.

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