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 the best way possible.

Today's Date: _____

PREGNANCY INTAKE FORM

PERSONAL INFORMATION:

Name_____
Age _____ Gender: Male __ Female __ Date of Birth _____
Home Address_____ City _____
Prov_____ Postal Code _____ Home phone (____) _____
E-mail address _____
Business Phone (____) _____Cell Phone (____) _____
Occupation_____Employer_____
Marital Status S M Partner D W Name of Partner _____
Names and Ages of Children_____
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 _____
Address (if known) _____
Phone _____Date of last visit? _____
Health Concern? _____
Name of Medical Doctor _____
Phone _____Date of last visit? _____
Address (if known)_____

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TRAUMA HISTORY:

Have you ever injured your spine, head, neck, rib/chest area, back, pelvis or hips? ___Yes ___No
Name: _____
Have you ever broken any bones or sprained any part of your body? ___Yes ___No
_____
Have you ever been hospitalized or had any previous surgeries? ___Yes ___No
_____

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 (ultrasound, amniocentesis, chorionic villus sampling)?
___Y ___N Please list dates, frequency and reason for these procedures:
_____
_____
Who is your birth care provider?
_____

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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?_____Filtered? __No __Yes, with?_____
Caffeine intake per day?_____ What form?_____
Do you add sugar, milk, cream?__No __Yes, how much?_____
Do you smoke or drink alcohol? ___Y ___N; How much/how often?_____

Sleep: Position?_____ Time to bed?_____
Time to sleep?_____ Time awake?_____
Fall asleep easily?__Yes __No Stay asleep?__Yes __No Number of Times Awake at Night _____

Rate your diet from 0 to 10 based on intake of fresh vegetables (ex: 1 serving per day - 1 cup = 2/10, 6 servings per day - 6 cups = 10/10) _____

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 (0 = completely stress free, 10 = unmanageable stress)
Professional?_____ Personal?_____

Happiness level 0-10 (0=depressed, 10 = joyful)
Professional?_____ Personal?_____

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 Nurse Midwife __Certified Midwife __Lay 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

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If yes, specify type: ___Pitocin ___Prostagland Gel (applied to your cervix) ___Unknown
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 time of service unless other arr angements 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 sub mit 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. This initial visit includes a health history/consultation and examination and may include any initial care that is determined to be clinically necessary and mutually agreed upon.

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

Thank you for choosing Hands on Health Family Chiropractic.
We look forward to helping you develop a healthier spine and nerve system.

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