Prenatal Health Questionanaire

Patient Name: ____ Date: ______________________________________

Congratulations on your current pregnancy! Please help us help you by providing us with the following information:

CURRENT PREGNANCY:

Position of baby (circle): Unknown Breech Posterior Transverse Vertex

weeks pregnant: ____________ Due Date: ____________

Gender of baby (circle): M F Baby #: ______________

Birth plan (circle): Home birth Birthing Center Hospital

Your delivery plan (circle all that apply): OB/GYN Midwife Doula Other: _______________________

PREVIOUS PREGNANCIES:

of previous pregnancies: ____________ # of previous deliveries: ____________

Delivery complications (circle): None Forceps Vacuum extraction Cesarean

Please explain any delivery complications: ____

____

____

If there was a cesarean, what was the reason?: ____

____

____

Please check any of the following that you would like more information on:

- ☐ Chiropractic care for infants & toddlers
- ☐ Prenatal yoga
- ☐ Prenatal massage
- ☐ Prenatal acupuncture
- ☐ Pregnancy support belts
- ☐ Baby wearing
- ☐ Birthing classes
- ☐ Doula recommendation
- ☐ Midwife recommendation
- ☐ OB/GYN recommendation
- ☐ Lactation consultant
- ☐ Meal planning
- ☐ Postpartum emotional wellness
- ☐ Other: _____________________

Webster Consent

Please initial each statement

__________I acknowledge that the Webster technique it a specific Chiropractic analysis and diversified adjustment. The goal of the adjustment is to establish balance to the structure (joints, muscles, and ligaments) of the mother's pelvis, improving neuro-biomechanical function and allowing the uterus to enlarge symmetrically with the growing baby.

__________I acknowledge that due to the cumulative effect of stress and trauma to the spine, pelvis, and sacrum over a lifetime, the diameter of the pelvic opening may be compromised which can lead to intrauterine constraint. According to Williams Obstetrics text, any diminished capacity of the pelvis or displacement of the sacrum can lead to dystocia (difficulty) during labor. The correction of these misalignments via the Webster Technique, can have a positive effect on (A) the mother's comfort level throughout pregnancy, (B) the ability of the baby to get into optimal positioning for birth, and (C) the causes of difficult labor.

__________I acknowledge that this is not a breech turning technique or External Cephalic Version procedure and that the Doctor will in no way be manually manipulating the baby's positioning. Often mothers report feeling an increase in the baby's movement later on in the day following an adjustment, which is considered positive because it indicates that the baby now has more room to do so.

__________I understand that in rare cases it is possible to have some minor soreness after my first few adjustments, especially if I have never been adjusted before. My Chiropractor will give me specific at home instruction to help avoid this.

__________I acknowledge that Chiropractic care throughout pregnancy allows for healthier function of the mother and baby. The Webster Technique is tailored to pregnant moms to create balance in the mother's pelvic bones, sacrum, and surrounding muscles and ligaments, therefore reducing the possibility of intrauterine constraint. This offers the baby to get into the best possible positioning for birth which can lead to a safer easier delivery. Chiropractic care during pregnancy is a safe, effective way to support the natural process of birthing.

__________I acknowledge that all Chiropractic care provided to me in the office will be performed by a licensed, experienced, certified Webster Technique Doctor of Chiropractic.

____ ____

Patient Name (printed) Signature

Date: ____________________

Patient Health Questionnaire

1. Describe your current symptoms (Begin with what bothers you the most): ____

____

2. Do your symptoms radiate (travel)? □ Yes □ No If yes, to what part of your body? ___________________________

3. How long have your symptoms been present? ____

4. When is it most noticeable? □ Upon Waking □ During the day □ Afternoon □ Evening □ While Trying to sleep

5. What activities make your symptoms worse?
□ Ice □ Rest □ Sitting □ Medication
□ Heat □ Activity □ Standing □ __________________

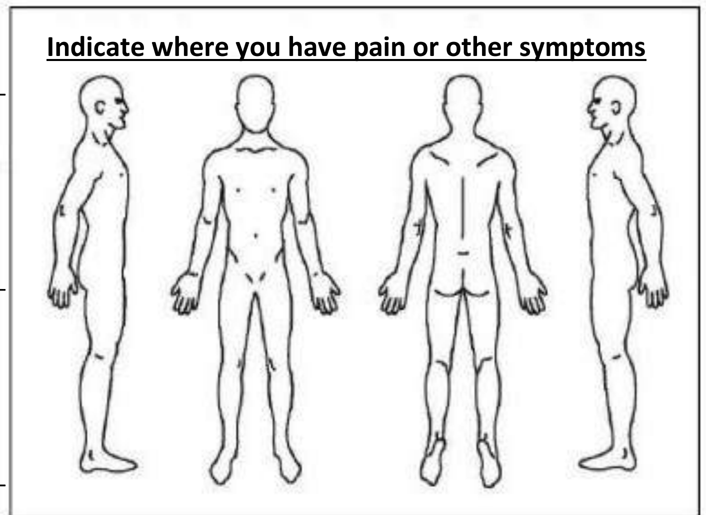
6. What activities make your symptoms better?
□ Ice □ Rest □ Sitting □ Medication
□ Heat □ Activity □ Standing □ __________________

7. What describes the nature of your symptoms?
□ Sharp □ Shooting
□ Dull Ache □ Burning
□ Numb □ Tingling

8. How often are your symptoms present?
□ Occasional (0-25%) □ Frequent (50-75%)
□ Intermittent (25-50%) □ Constant (75-100%)

9. How are your symptoms changing?
□ Getting Better
□ Not Changing
□ Getting Worse

Indicate where you have pain or other symptoms



10. Who else have you seen for your current symptoms?
□ No One □ Medical Doctor □ OB/GYN
□ Other Chiropractor □ Physical Therapist □ Midwife
Provider's name: __________________________

11. What tests have you had for your symptoms? □ None □ MRI date: ________________
□ X-rays date :______________ □ CT Scan date: _____________

12. What describes the severity of your symptoms? **None 1 2 3 4 5 6 7 8 9 10 Severe**

13. What other forms of care have you tried for your current complaint?
□ Nothing □ Muscle Relaxer □ Advil / Tylenol / Aleve (circle) □ Injections
□ Pain Medication □ Ice / Heat (circle) □ Physical Therapy □ Other____________________

14. What do you feel caused your symptoms? □ Fall □ Lifting □ Work
□ Car Accident □ Don't Know □ ________________________

15.What activities are affected by your symptoms?
□ Work/School (circle) □ Sleeping □ Driving/Riding in Car (circle) □ Golf □ Exercising
□ Walking □ Running □ House Work □ Yard Work □ ________________________

LE: CL:

For each of the conditions listed below, place a check in the* PAST *column if you have had the condition in the past.

Place a check in the* PRESENT *column if you currently have the conditions listed.

<u>Many of the following conditions respond to chiropractic and acupuncture</u>

16. 17.

PAST	PRESENT	
( )	( )	Headaches
( )	( )	Neck Pain
( )	( )	Upper Back Pain
( )	( )	Mid Back Pain
( )	( )	Low Back Pain
( )	( )	Scoliosis
( )	( )	Shoulder Pain
( )	( )	Elbow Pain
( )	( )	Wrist Pain
( )	( )	Hand Pain
( )	( )	Hip Pain
( )	( )	Knee Pain
( )	( )	Ankle Pain
( )	( )	Foot Pain
( )	( )	Jaw Pain/TMJ
( )	( )	Joint Swelling/Stiffness
( )	( )	Arthritis
( )	( )	Rheumatoid Arthritis
( )	( )	Osteoporosis/Osteopenia
( )	( )	Lyme Disease
( )	( )	General Fatigue
( )	( )	Ringing in Ears
( )	( )	Visual Disturbances
( )	( )	Dizziness
( )	( )	Nausea

PAST	PRESENT	
( )	( )	High Blood Pressure
( )	( )	Low Blood Pressure
( )	( )	High Cholesterol
( )	( )	Heart Attack
( )	( )	Chest Pains
( )	( )	Stroke
( )	( )	Angina
( )	( )	Kidney Stones
( )	( )	Kidney Disorder
( )	( )	Bladder Infection
( )	( )	Painful Urination
( )	( )	Loss of Bladder Control
( )	( )	Prostate Problems
( )	( )	Reflux/Heartburn
( )	( )	Abnormal Weight Gain
( )	( )	Abnormal Weight Loss
( )	( )	Loss of Appetite
( )	( )	Constipation
( )	( )	Abdominal Pain
( )	( )	Ulcer
( )	( )	Hepatitis
( )	( )	Liver Disorder
( )	( )	Gall Bladder Disorder
( )	( )	Cancer
( )	( )	Tumor
( )	( )	Asthma
( )	( )	Chronic Sinusitis
( )	( )	Seasonal Allergies

PAST	PRESENT	
( )	( )	Diabetes
( )	( )	Excessive Thirst
( )	( )	Excessive Urination
( )	( )	Hypo-Thyroid
( )	( )	Hyper-Thyroid
( )	( )	Smoking/Tobacco Use
( )	( )	Drug/Opioid Dependence
( )	( )	Alcohol Dependence
( )	( )	Food Allergies
( )	( )	Depression
( )	( )	Anxiety
( )	( )	Frequent Illness
( )	( )	Epilepsy
( )	( )	Dermatitis
( )	( )	Eczema
( )	( )	Poison Ivy/Oak
( )	( )	HIV/AIDS
( )	( )	Hot Flashes
( )	( )	Hormone Replacement
( )	( )	Birth Control Pills
( )	( )	Painful Periods/Cramps

18. Primary Care Physician_____________________________ **18b.** Date of Last Medical Physical____________________

19. Indicate if an immediate family member has had any of the following:

(1) Rheumatoid Arthritis (2) Heart Problems (3) Diabetes (4) Cancer (5) Lupus (6) Other: ___________

20. List all prescription and over-the-counter medications, nutritional/herbal supplements you are taking:

____

21. List all the surgical procedures you have had AND times you have been hospitalized (INLCUDING GIVING BIRTH):

____

22. ***<u>ANY & ALL LIFETIME TRAUMA HISTORY</u>*** to head, neck, or back (such as concussion, automobile accidents, sports injuries, work-related accidents, etc)...EVEN IF YOU DID NOT HAVE ANY SYMPTOMS OR TREATMENT, STILL NOTE THE TRAUMA PLEASE.

____

____

Patient Signature____ Date_________________________

Patient Introduction Card

Today's Date ________________ Account #_______________

Full Legal Name ____ Prefer To Be Called___________________

Home Address____ Occupation_________________________

City________________________ State_______ Zip____________ Employer___________________________

Home Phone____________________________ Name of Insurance Co_________________

Cell Phone________________________ ***Provider***_____________ Policy Holder Name __________________

Work Phone____________________________ Policy Holder Date of Birth _____________

Email_________________________________ Primary Care Doctor__________________

Date of Birth __________________ Age______ Previous Chiropractic Care? ☐ YES ☐ NO

☐ Married ☐ Single ☐ Other___________ Major Complaint Today________________

Social Security #_________________________ ___________________________________

Preferred method of contact for appointment reminders ☐ Phone ☐ Email ☐ Either is fine

Who (or what source) referred you to our office? ____

It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged