Pregnancy Intake Form

Name_____ Sex: M or F Birthday: _____

Address:_____City:_____Zip:_____

Soc. Sec. # _____-_____-_____ Home #:_____Cell #: _____

Cell Phone Provider: _____Email:_____ Marital Status:_____

Children, Ages:_____ Spouse's Name:_____

Your Occupation: _____ Employer: _____

Preferred Contact: Circle One- Home Cell Work Email: _____

Current Health Challenge: (If this portion does not apply to your pregnancy please skip to the next section.)

What is your major complaint? _____

_____

How long have you had this condition?_____ Is it: Improved Worse Unchanged

Have you had similar conditions in the past?_____ Is it interfering with: work sleep or daily routine

Do any positions make it worse?_____

Do any positions make it better?_____

Other doctors or therapists that have treated THIS condition:_____

What do you think caused this condition?_____

Use the diagram to the left to illustrate your symptoms:

Aches: ^^^ Numbness: ooo Pins/Needles: xxx Stabbing: ///

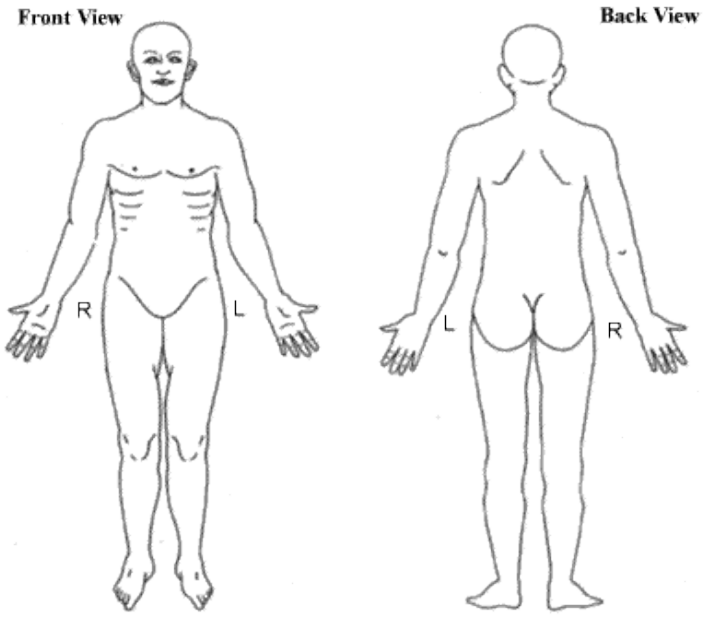
Scale of 1-10, 10 being the worst rate your symptoms according to the following***:

Current pain level: _____ % of time at this level: _____

Average Pain level: _____ % of time at this level: _____

Worst Pain level: _____ % of time at this level: _____

*** Please do this for each symptom.



Patient Signature: _____ Date_____

How many weeks of pregnancy are you? _____ Date of Missed Period?_____

How many pregnancies have you had?_____ Miscarriages?_____ Abortions? ____

Do you have a birth plan? Yes or No

Have you ever had surgery in the genital region? ___

If yes, describe: _____

Any history of large babies in your or the baby's father's family or in previous pregnancies?_____

Do you currently work? If so, describe your duties _____

_____

Will your birth be: with a midwife with a OB at home at hospital birthing center undecided

Name of Ob/Midwife and Contact information:_____

Are you ok with the use of the following (circle):epidural pitocin vaccinations at birth ultrasounds

How many ultrasounds have you had? _____

Are you currently taking any supplements or medications? If yes, what and how much?

_____

Have you been told your blood pressure is high?_____

Describe your diet:_____

_____

Pregnancy Emotions

How did you feel when you found out you were pregnant? _____

_____

What is your current living situation? (I.e. Married, Single, other children at home, smokers)_____

_____

How many hours per day would you say you spend connecting with your baby? (talking to him/her, singing, etc.)

_____

_____

Rate your stress on a scale of 1-10 _____

Other History:

Patient Signature: _____ Date_____

Please Check all of the following that apply to you:

__ Alcohol/Drug Dependence	__ Recent Fever	__ Diabetes
__ High Blood Pressure	__ Stroke	__ Corticosteroid Use
__ Taking Birth Control Pills	__ Dizziness/Fainting	__ Numbness
__ Cancer/Tumor	__ Osteoporosis	__ Epilepsy/Seizures
__ Prostate Problems	__ Menstrual Problems	__ Urinary Problems
__ Currently Pregnant-Weeks___	__ Abnormal Weight	__ Morning Pain/Stiffness
__ Pain Unrelieved by Rest	__ Pain at Night	__ Visual Disturbances

List surgical operations and years:_____

_____

Do you have a family physician? Name:_____

Medications and Frequency _____

_____

Medication Allergies _____

Supplements: _____

Are you vaccinated? Yes or No

Allergies?_____

Have you been in an accident or had any other personal injury? _____ Describe: _____

_____

Have you recently been diagnosed with hypertension?: Yes No If yes, describe: _____

Have you recently been diagnosed with diabetes?: Yes No If yes: Type 1 or Type 2

If you answered yes to diabetes was your blood lab work test for hemoglobin A1c >8.0%?: Yes No

If you know your hemoglobin A1c, please write it in: _____

Have you had an X-ray or CT scan or MRI of your lower back spine within the last 28 days?: Yes No

Family History:

Are there any diseases that run in your family? _____

_____

Patient Signature: _____ Date_____

What is the state of health of your parents?_____

_____

What is/was the state of health of your grandparents?_____

_____

Social History:

Race: ☐ Caucasian ☐ Asian or Pacific Islander ☐ African American ☐ Hispanic ☐ Native American or Alaskan Native

Ethnicity: ☐ Latino ☐ Non-Latino

Smoking History: ☐ Never ☐ Quit- Number of years smoked:_____ Cigarettes/Day:_____

☐ Current Smoker: Number of years:_____ Cigarettes/Day:_____

Current Weight?____ Current Height? _____ Have you recently lost or gained weight?_____

Would you consider your Mental work to be: Heavy Moderate Light Hours/day:_____

Would you consider your Physical work to be: Heavy Moderate Light Hours/day:_____

What do you do for exercise? How many hours per week do you exercise?_____

Alcohol: Beer/week:_____ Liquor/wk:_____ Wine/wk:_____ # of years:_____

Caffeine (coffee, tea, pop): Cups/day:_____ #of years: _____

Aspirin: #/day:_____ # of years:_____

Is there anything else you would like us to be made aware of?_____

_____

_____

By my signature below I agree to the following:

I consent to the performance of examination and treatment on me or on _____ by the Doctors of Natural Potential Chiropractic. I have discussed with the doctor the nature and purpose of the procedures performed in this office. I understand that neither chiropractic care nor medical treatment is an exact science and that care may involve judgments based on the facts known by the doctor. The doctor uses this judgment to explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected, but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interest.

I, further, understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which includes rarely, but not limited to fractures, disc injuries, strokes, and strains/sprains and am therefore willing to accept and consent to the risk associated with the care I am about to receive. I have read, or the afore mentioned information has been explained regarding consent. I have had an opportunity to ask

Patient Signature: _____ Date_____

questions about my exam and treatment. By signing below I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

I certify to the best of my knowledge, the above information is complete and accurate. If the health information is not accurate, or I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor to contact my physician, if necessary.

For Female Patients, not currently pregnant: By my signature on this form I state to the best of my knowledge I am not pregnant, nor is pregnancy suspected or confirmed at this particular time.

Date of last menstrual period: _____

Patient's Printed name: _____

Patient's Signature: _____

Relationship of authority if not signed by patient: _____ Date _____

Witness: _____

Patient Signature: _____ Date_____