

Pregnancy Health History Form

Name: _____ Date: _____
Age: _____ Birth date: dd/mm/yyyy _____ Sex: F Patient Number: ____
E mail address: _____
Address: _____
Phone:(H) _____ (W) _____ (cell) _____ Marital Status: S M W D CL
Occupation: _____ Who may we thank for referring you? _____
Family doctors name and address: _____

WHY THIS FORM IS IMPORTANT Our focus is on assisting clients to function optimally, for them to become more self aware, stronger, healthier and for improved adaptation to everyday stresses. Completion of this form provides us with an improved understanding of your physical, emotional and chemical stresses that can gradually overwhelm the body over time and contribute to health problems. Please complete this form as thoroughly as possible and the doctor will review it with you. Information on this form is strictly confidential and will not be shared without your consent.

#1 Current Health Concern (if there are no current concerns and this assessment is to ensure optimum health, function and wellness tick this box)

2 About Your Pregnancy: (circle answer)

Is this your first pregnancy? **Yes / No**

If this is not your first, how many times have you been pregnant? _____

Have you had any complications with previous pregnancies? **Yes / No** (explain if yes)

If you have had miscarriage(s), how far along in your pregnancy did it occur?

Was this pregnancy planned? **Yes / No**

What is the estimated date of delivery? _____

Who is your primary care giver for delivery? Obgyn / GP/ Midwife? Name: _____

What is your planned location for delivery? Hospital / Home/ Birthing clinic/other

How do you feel about this pregnancy? _____

Have you a birth plan? **Yes / No**

Would you like information on creating one? **Yes / No**

Any special arrangements for the birth? (planned C-sec, water delivery, birth chair, squat, other) _____

Would you like additional information on options for birth posturing? **Yes / No**

Have you had any testing? Genetic, blood, ultrasound, amniocentesis, chorionic villi sampling, other)?

Dates and reasons: _____

Are you planning on breastfeeding post delivery? **Yes / No**

Would you like further information on the advantages of breastfeeding? **Yes / No**

Was your blood pressure prior to pregnancy within normal range, low or high? _____

What is your present blood pressure and when was it last checked? _____

Have you changed your diet/menu since learning of your pregnancy? **Yes / No**

Would you like further information on healthy nutrition for pregnancy? **Yes / No**

Have you smoked prior to or along with this pregnancy? **Yes / No / Quit (date):** _____

Have you had alcohol during this pregnancy? **Yes / No** _____

Have you noticed:

Swelling in the arms or legs? (circle) **Yes / /No**

Low back pain? **Yes / No** How often? _____

Upper back pain? **Yes / No** How often? _____

Neck pain? **Yes / No** How often? _____

Rib or chest pain? **Yes / No** How often? _____

Any foot pain? **Yes / No** How often? _____

Digestive complaints? Heartburn, constipation? **Yes/ No** _____

Nausea or vomiting? **Yes / No** Frequency and when? _____

Arm or hand numbness/tingling? **Yes / No** How often? _____

Dizziness or lightheadedness? **Yes / No** How often? _____

Headaches? **Yes / No** How often? _____

Pain radiating down the leg(s)? **Yes / No** How often? _____

Heart palpitations? **Yes / No** How often? _____

If pain from anything noted above is involved, rank it on a scale of 1 to 10 (1 is minimal, 10 is extreme)

_____ Circle or describe it's character (sharp, dull, ache, burning, tingling, throbbing, spasms, other)

_____ When did you notice it? _____

What happened? _____ What relieves? _____

What aggravates? _____

Does it radiate or cause problems elsewhere? _____

Any associated or related concerns? _____

Professionals seen for this? (name) _____

Treatment and results _____

Other health concerns: Please note all other health concerns present or in the past.

Diseases history: (please circle all that apply)

Allergies, Stuffy nose, Runny sinuses, Frequent colds, Lowered resistance, Loss of balance, Difficulty concentrating, Fatigue, Indigestion, Bloating, Appendicitis, Asthma, Bronchitis, Emphysema, Pneumonia, Bleeding disorders, Cancer, Cataracts, Vision changes, Diabetes, Hypoglycemia, Epilepsy, Heart Disease, Hypertension, Migraines, Hepatitis, High cholesterol, Difficulty digestion, Loose stools, Hernia, Herniated Disc, Kidney Disease, Liver disease, Multiple Sclerosis, Osteoarthritis, Rheumatoid arthritis, Osteoporosis, Parkinson's Disease, Thyroid problem, Tonsillitis, Ulcers, Urinary tract infections, Ulcerative colitis Other (list):

#3 Physical stresses

Any significant injuries, falls or traumas during infancy or childhood? **Yes No Unsure**

(if yes please explain) _____

Any significant injuries, falls or traumas (car accidents) during adulthood? **Yes No Unsure**

(if yes please explain) _____

Any hospital visits? **Yes No** Explain _____

Have you had any surgeries, fractures? **Yes No** Explain and dates _____

Are you in prolonged postures (ex: repetitive work, lifting, sitting, driving) **Yes No Unsure**

(if yes, please explain) _____

Any hobbies that are physically strenuous or have repetitive movements? **Yes No Unsure**

(if yes, please explain) _____

What is your usual exercise routine? _____

Any fractured bones or dislocations? _____

Any vehicle accidents? **Yes No** What happened and when? _____

#4 Chemical Stresses

Are you taking prescription or over-the-counter medications? **Yes / No** (If yes, please indicate what you are taking and why) _____

Are you currently taking supplements? **Yes / No**(if yes, which ones and why?) _____

Do you drink bottled water? **Yes / No / Occasionally**

Are you exposed to pollutants, strong smells, chemicals, aerosols? **Yes No Occasionally**

Do you eat organic? **Yes / No / Occasionally**

Do you use natural or environmentally friendly products in your home? I.E. Cleaning supplies, hair and makeup, etc.

Yes / No _____

Do you drink or bathe/shower in chlorinated water? **Yes / No** _____

#5 Mental/Emotional Stresses

Since psychological stress has been shown to affect numerous systems and fetal function, please let us know how you are coping with life's stresses. Rank from 1 to 10 with 1 being minimal to 10 being extreme)

Life in general I feel _____ Work and Career I feel _____ Relationships I feel _____

Financial stress I feel _____ Time management I feel _____ Sports & hobbies I feel _____

Health and well-being I feel _____ Quality of sleep I feel _____ About my pregnancy I feel _____

If you are experiencing significant or ongoing stress please explain _____

Do you practice some form of meditation, breath work, other mind-body movement or have a routine to reduce your stress? **Yes /No** Explain _____

Are you interested in learning about stress reduction practices? **Yes / No**

#6 Family Health History

Please note any health issues that are present with family members such as parents, siblings, significant other or children. Cancer, hypertension, stroke, arthritis, kidney disease, dementia, diabetes, other

#7 Why are you here?

People seek chiropractic care for a number of reasons and have certain expectations and perceptions. Please tick the goals which apply to you so we can accommodate your wishes.

Improvement in function ___ Pain reduction ___ Relief ___ Improved quality of life _____

Manage my crisis ___ Information on prevention ___ Symptom management _____

Healthier immune system ___ Stress reduction ___ Keep me moving ___ Optimum function and quality of life _____

Improved performance ___ Full body integration ___ Wellness ___ Longevity _____

Other _____

CONSENT for examination and care once a report if findings has been reviewed.

Please Read Carefully

In order for my health professional as indicated below to make a determination on the suitability of my case for care, I acknowledge and understand that I must complete a thorough evaluation. I do hereby request and consent to the performance of such an evaluation by the person(s) named below, or any party authorized to do so by that person.

I have had the opportunity to discuss with the Doctor of Chiropractic indicated below, or with any party authorized to do so by that Chiropractor, about the nature and purpose of the examination process. I understand that there may be remotely associated risks with examinations, as there are with any and all healthcare treatments. In healthcare, the matter of whether any treatment is appropriate or not is determined by looking at the level of risk and comparing this with the level of expected benefit. I understand that I may ask the doctor to stop the examination at any time. I also understand that by signing this form, the chiropractor continues to be obligated for best practices delivered in my interests.

Name:

Date:

Signature:

Witness: