PRENATAL CHIROPRACTIC INTAKE

PATIENT INFORMATION

## Date:

Preferred Name: Last Name: \_

Date of Birth (M/D/Y): \_

Age: \_

Gender Pronoun:

Address:

City: Province:

Postal Code:

Phone (h) (c) \_ Email: \_ Alberta Health Care # : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMERGENCY CONTACT:

 Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOW DID YOU HEAR ABOUT DR. STEPHANIE?

Referral or Other:

HEALTH CARE PROVIDERS:

Family Doctor: Massage Therapist: Acupuncturist/Naturopath: \_ OBGYN: Other Care Providers:

MOTOR VEHICLE ACCIDENT / WORK RELATED (IF APPLICABLE)

Is this condition related to: Work? \_ Yes \_ No

Has your employer been notified? Yes \_ No

Motor vehicle accident? \_ Yes \_ No Date of injury:

Have you seen another practitioner in regards to this accident? Y/N Practitioner Name:

Insurance Company: Phone number:

Claim #:

PRENATAL QUESTIONNAIRE

Please check/circle/fill in the following information to give us a detailed picture of your pregnancy. I am in my first in my 1st/2nd/3rd trimester. I am weeks.

My Due Date is

This is my (1st/2nd/3rd /4th …?) pregnancy.

Any children? Ages? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I am planning to have my birth at

I am under the care of the following health care providers (OBGYN/Midwife/Doula)

Have there been any issues/concerns with any of your check-ups so far? If so please explain

I am currently experiencing the following: (please circle applicable items)

Nausea / vomiting / dizziness Fatigue

Stress / worry / fear Sleep disturbance Swelling

Cramping Spotting

Gestational Diabetes High/ Low Blood Pressure Shortness of breath

Difficulty walking/sitting/standing

P ain:

Under the ribs

In my low back/pelvis/pubic bone On the sides of my hips

In my arms / legs

In my neck Across my shoulders/between my shoulder blades Tension/pulling under my belly

Other (please explain)

 -

 \_ The position of my baby is: Head down / Transverse / Breech / Unknown

POSTNATAL HISTORY (IF APPLICAPLE)

Describe your previous birth experience (s) \_ \_

 \_ \_

 \_ \_

Vaginal delivery / C-section / vacuum / forceps / episiotomy /Induction

Labour time \_ Baby weight \_ length \_

Concerns or Complications:

Breastfeed \_ for how long? \_

Please describe any over the counter or prescription medications you are currently taking

 \_ \_ \_

Please list all supplements/vitamins that you are currently taking

 \_ \_ \_

Do you have any specific concerns you’d like us to address?

 \_ \_ \_ Have you ever experienced:

* Heaviness in the pelvic floor
* Pelvic pain
* Pain with intercourse
* Leaking urine with stress (coughing/sneezing/jumping/running)
* Urgency with bowel or bladder function
* Change in bowel or bladder function
* Tenting of the abdomen
* Pain in the hips or low back
* Other: \_ \_

CURRENT HEALTH CONDITION

## \*Reason for this appointment/major complaint:

\*How did this compliant occur:

\*When did your condition begin: days /weeks/months/years

\*Have you had this condition before: Y/N

\*Is your condition getting: Better/ Worse/ No change

\*Symptoms came on: Suddenly/ Come & Go

\*Indicate the **severity** of the **pain** by circling one of the following numbers:

*(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Extreme Pain)*

\*Describe the character of your pain: (dull & achy, sharp/stabbing, shooting, throbbing)

\*What activities make this condition better? (ice, heat, stretching, resting):

\*What activities make this condition worse? (activity, certain movements, prolonged standing/sitting):

\*Have you experienced radiating pain/ numbness/ tingling/ weakness since your condition began. If so please specify where:

**\*Please use the symbols below to mark on the pictures where you are experiencing your current pain.**

Numbness = = = Dull Ache OOO Burning XXX Sharp/Stabbing / / / Pins, Needles + + +

Other ^ ^ ^

## \*Symptoms are BETTER in: AM / midday / PM/ Do not change with time of day

\*Symptoms are WORSE in: AM / midday / PM / Do not change with time of day

\*Can you perform your daily activities: Y/N/some

\*Can you perform your daily work activities: Y/N/some

\*Have you seen other Doctors/Health Care Providers for this condition? :

\*Please list ALL medications/supplements you are taking (prescriptions, vitamins, herbal supports, BCP, aspirin, etc) & for what conditions? :

\*Women: Are you pregnant? Y/ N How many weeks? Due Date:

\*Have you had previous Chiropractic Care: Y/ N Date:

\***What are your goals with this treatment**?

HABITS:

Caffeine: cups/days: Smoking: packs/day: Alcohol: drinks/wk:

Sleep: hours/night: Exercise: none/moderate/daily What kind:

Stress level: none /mild /moderate /high

PAST HEALTH HISTORY:

**Have you ever been diagnosed with any of the following:**

\*High blood pressure: Y/N \*Hardening of arteries (arteriosclerosis): Y/N \*Diabetes: Y/N

\*Heart/blood disease: Y/N \*Stroke: Y/N \*Arthritis: Y/N \*Fibromyalgia: Y/N

\*Cancer: Y/N \*Other conditions: \_

List any **Surgeries**: List any **Hospitalizations**: List any **Accidents/Falls**: \_

Family History

Is there a **history in your family** of cancer, diabetes, heart attack, high blood pressure, stroke, arthritis or neck/back pain?

Father: \_ Mother: \_ Siblings:\_ \_Grandparents:

SYSTEMS REVIEW:

Please **CHECK** any of the following conditions you are experiencing **currently & underline**

t hose you have experienced in the **past**:

**GENERAL SYMPTOMS**

* + Fever
	+ Sweats
	+ Fainting
	+ Sleep Disturbance
	+ Fatigue
	+ Nervousness
	+ Weight Gain
	+ Weight Loss

**NEUROLOGICAL**

* + Visual Disturbance
	+ Dizziness
	+ Fainting
	+ Convulsions
	+ Headache
	+ Numbness
	+ Neuralgia ( Nerve Pain)
	+ Poor Coordination

**MUSCLE & JOINT**

* + Neck Pain
	+ Low Back Pain
	+ Arm pain
	+ Shoulder pain
	+ Leg pain
	+ Knee pain
	+ Foot pain
	+ Pain/ numbness in arms/legs
	+ Pain between the shoulders
	+ Swollen joints
	+ Spinal Curvature
	+ Arthritis
	+ Fractures

**RESPIRATORY**

* Chronic Cough
* Spitting up phlegm
* Spitting up blood
* Chest Pain
* Wheezing
* Difficulty Breathing
* Asthma

**CARDIOVASCULAR**

* Rapid beating heart
* Slow beating heart
* High blood pressure
* Low blood pressure
* Pain over heart
* Hardening of arteries
* Swollen ankles
* Poor circulation
* Palpitations
* Cold hands or feet
* Varicose Veins

**EARS/EYES/NOSE/THROAT**

* Eye pain
* Double vision
* Ringing in ears
* Deafness
* Nosebleeds
* Trouble swallowing
* Hoarseness
* Sinus infection
* Nasal Drainage
* Enlarged glands

**GENITOURINARY**

* Frequent urination
* Painful urination
* Blood in urine
* Pus in urine
* Kidney infection
* Prostate trouble
* Uncontrollable urine flow

**GASTROINTESTINAL**

* Poor appetite
* Difficult digestion
* Heartburn
* Ulcers
* Nausea
* Vomiting
* Constipation
* Diarrhea
* Blood in stool
* Gallbladder/jaundice
* Colitis/ Crohn’s

**WOMEN**

* Painful menstruation
* Hot flashes
* Irregular cycle
* Cramps or back pain
* Vaginal Discharge
* Nipple Discharge
* Lumps in breast
* Menopausal symptoms
* Birth control pills
* Miscarriages
* Complications with pregnancy

**CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION**

# C ONSENT TO CHIROPRACTIC TREATMENT – FORM L

It is important for you to consider the benefits, risks and alternatives to the treatment options offered by your chiropractor and to make an informed decision about proceeding with treatment. Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body, soft-tissue techniques such as massage, and other forms of therapy including, but not limited to, electrical or light therapy and exercise.

**Benefits**

Chiropractic treatment has been demonstrated to be effective for complaints of the neck, back and other areas of the body caused by nerves, muscles, joints and related tissues. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility, improve function, and reduce or eliminate the need for drugs or surgery.

**Risks**

The risks associated with chiropractic treatment vary according to each patient’s condition as well as the location and type of treatment. **The risks include:**

* **Temporary worsening of symptoms** – Usually, any increase in pre-existing symptoms of pain or stiffness will last only a few hours to a few days.
* **Skin irritation or burn** – Skin irritation or a burn may occur in association with the use of some types of electrical or light therapy. Skin irritation should resolve quickly. A burn may leave a permanent scar.
* **Sprain or strain** – Typically, a muscle or ligament sprain or strain will resolve itself within a few days or weeks with some rest, protection of the area affected and other minor care.
* **Rib fracture** – While a rib fracture is painful and can limit your activity for a period of time, it will generally heal on its own over a period of several weeks without further treatment or surgical intervention.
* **Injury or aggravation of a disc** – Over the course of a lifetime, spinal discs may degenerate or become damaged. A disc can degenerate with aging, while disc damage can occur with common daily activities such as bending or lifting. Patients who already have a degenerated or damaged disc may or may not have symptoms. They may not know they have a problem with a disc. They also may not know their disc condition is worsening because they only experience back or neck problems once in a while.
	+ Chiropractic treatment should not damage a disc that is not already degenerated or damaged, but if there is a pre-existing disc condition, chiropractic treatment, like many common daily activities, may aggravate the disc condition. The consequences of disc injury or aggravating a pre-existing disc condition will vary with each patient. In the most severe cases, patient symptoms may include impaired back or neck mobility, radiating pain and numbness into the legs or arms, impaired bowel or bladder function, or impaired leg or arm function. Surgery may be needed.
* **Stroke** – Blood flows to the brain through two sets of arteries passing through the neck. These arteries may become weakened and damaged, either over time through aging or disease, or as a result of injury. A blood clot may form in a damaged artery. All or part of the clot may break off and travel up the artery to the brain where it can interrupt blood flow and cause a stroke.
	+ Many common activities of daily living involving ordinary neck movements have been associated with stroke resulting from damage to an artery in the neck, or a clot that already existed in the artery breaking off and travelling up to the brain.
	+ Chiropractic treatment has also been associated with stroke. However, that association occurs very infrequently, and may be explained because an artery was already damaged and the patient was progressing toward a stroke when the patient consulted the chiropractor. Present medical and scientific evidence does not establish that chiropractic treatment causes either damage to an artery or stroke.

The consequences of a stroke can be very serious, including significant impairment of vision, speech, balance and brain function, as well as paralysis or death.

**Alternatives**

Alternatives to chiropractic treatment may include consulting other health professionals. Your chiropractor may also prescribe rest without treatment, or exercise with or without treatment.

**Questions or Concerns**

You are encouraged to ask questions at any time regarding your assessment and treatment. Bring any concerns you have to the chiropractor’s attention. If you are not comfortable, you may stop treatment at any time.

**Please be involved in and responsible for your care. Inform your chiropractor immediately of any change in your condition.**

**DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE CHIROPRACTOR**

I hereby acknowledge that I have discussed with the chiropractor the assessment of my condition and the treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I hereby consent to chiropractic treatment as proposed to me.

 Date: 20 . Name (Please Print)

 Date: 20 . Signature of patient (or legal guardian)

 Date: 20

Signature of Chiropractor