

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: _____
Occupation: _____

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.

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

Pain:

Under the ribs

In my low back/pelvis/pubis 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 APPLICABLE)

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 complaint 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 == =

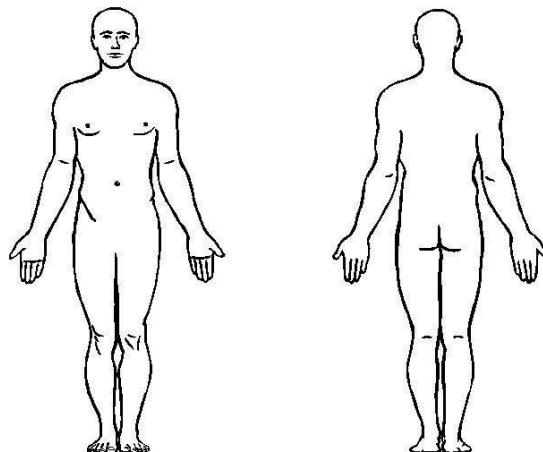
Dull Ache OOO

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** those 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

CONSENT 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