

New Patient Application - Pregnancy

Welcome to our Practice! Please thoroughly complete all questions. Thank you.

Name: _____ Today's Date: _____

Preferred Name: _____ Birthdate: ___/___/___ Age: _____

Address: _____ Email: _____

City/State/Zip: _____ Receive quarterly Newsletter: Yes / No

Phone: Home: _____ Work: _____ Cell: _____

Status: Married / Widow / Divorced / Single Social Security #: _____

Who may we thank for referring you? _____

Occupation: _____

Employers name: _____ Phone: _____

Spouse's name: _____ Phone: _____

Spouse's employer: _____ Phone: _____

Children's names & ages: _____

Emergency Contact: _____ Phone: _____ Other: _____

Favorite hobbies or interests: _____

Your Prior Doctor of Chiropractic: _____

City, State: _____ Approximate date of last Chiropractic treatment: _____

Chiropractic adjusting techniques you've had success with: _____

General Practitioner name: _____

Phone: _____ City, State: _____

Please rate 1 (poor) to 10 (excellent) the quality of healthcare you feel you receive from your GP:

Other Specialists you are currently under care with:

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Method of payment for first visit

___ Cash ___ Check ___ Credit Card

Person Responsible for payment:

Name: _____

Phone Number: _____

Address: _____

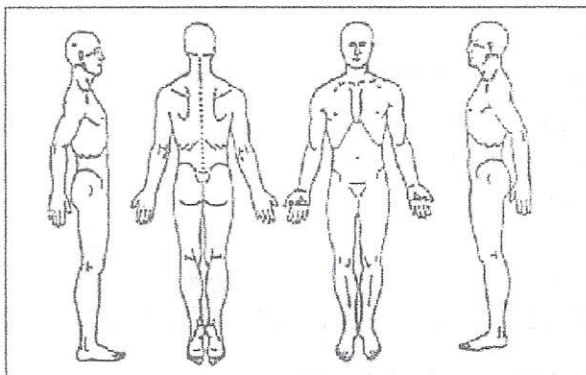
City: _____

State/Zip: _____

Do you have Health (crisis) Insurance? Y N

Insurance Company: _____

Mark Area(s) of Health Concerns:



Health reasons for consulting our office:

1. _____ 2. _____
3. _____ 4. _____

Have you had same or similar problem(s) before? Yes No

How long? _____ Please explain: _____

Does this condition interfere with your: work sleep daily routine _____
Father/Mother/Brother/Sister/Children, with similar problems?

Is this the result of an auto or work injury? _____ If so, when? _____

If this is a work injury, is there a panel chiropractor that your company's Workmen's Compensation Insurances requires you to see in the first 90 Days? If so, who? _____

Other doctors who have treated this problem: _____

What treatments did you receive: _____

Medication(s) you currently take: _____

Do you take supplements? Yes or No If yes, please list _____

Is there any chance you are pregnant? Yes No

What do you understand chiropractic care to be? _____

Do you know what a subluxation is? Yes or No If yes, please describe: _____

Do you play any sports or exercise regularly? Yes or No If yes please describe _____

Do you smoke? Yes or No If yes how many cigarettes/packs a day? _____

If any of the following have happened to you, give approximate dates & briefly describe injury:

Auto Accidents: _____ Motorcycle accidents: _____

Falls or other injuries: _____ Spinal or neck injuries: _____

Broken Bones: _____ Knocked unconscious: _____

Surgeries: _____ Health problems of parents: _____

Do you or have you had any of the following? Please write *C* of current and *P* for Past

Angina Arthritis Asthma Allergies Carpal Tunnel Cancer Diabetes Emphysema Gout Heart
Disease High Blood Pressure Kidney Disease Low Blood Pressure Migraines Numbness/tingling Sciatica
 Seizures Sinus Problems Spinal curvature Stroke Thyroid disorder Tuberculosis Ulcers

The above information is true and accurate to the best of my knowledge. My reason for consultation with the Doctor is for evaluation of my physical health and the potential for improvement.

Patient or Guardian Signature: _____

Date: ___/___/___

Pregnancy Specific History

Prenatal history:

1) Is this your first pregnancy? _____

2) How many other births have you had? _____

3) How many weeks pregnant are you now? _____ Due Date: _____

4) Have you experienced any traumas (accidents, falls) during this/past pregnancy? _____

Please describe: _____

6) Do you smoke or drink alcohol? _____

7) Have you had any evaluation procedures (ultrasound, amniocentesis, chorionic villus sampling)?

8) Please list dates, frequency and reason for these procedures:

9) How has your diet been during this pregnancy? _____

10) Have there been any stressful events in your life during this pregnancy? _____

11) What are your most significant fears associated with this birth? _____

12) Who is your birth care provider? _____

13) Will you have someone with you at birth for support (other than birth care provider)?

Please specify who: _____

14) Where do you plan on delivering? _____

15) Have you put together a birth plan? _____

Previous Birth History:

Please print this page for each previous delivery

- 1) Place of birth: Hospital, Birthing Center, Home.
- 2) Delivering Practitioner: OB/Gyn, Certified Nurse Midwife, Certified Practicing Midwife, Lay Midwife _____
- 3) Position of Delivery: Lithotomy position (on back with feet up), On Your Side, Kneeling, Squatting, Other? _____
- 4) Was labor induced? (Contractions were stimulated prior to the natural onset of labor) Yes No
If yes, specify type: Pitocin, Prostagland Gel (applied to your cervix), Unknown
- 5) Were your membranes ruptured by your care provider? Yes No Unknown
- 6) Were contractions stimulated intravenously with pitocin once labor started? Yes No
- 7) Did you receive any pain medications or anesthesia? Yes No Unknown Type _____
If you had an epidural, how many centimeters were you dilated when it was administered? _____
- 8) Did you experience back pain during labor? Yes No Unknown
- 9) Did you deliver vaginally? Yes No
- 10) Baby presentation at time of delivery: Normal, Posterior, Brow, Facial, Breech,
If breech, specify type: Footling, Frank, Complete, Kneeling
Was there any visible injury to your baby? Yes No Unknown
If so, where on your baby was the injury sustained? _____
- 11) Did your care provider assist delivery with his/her hands? Yes No Unknown
Was there any turning of the neck, or traction (pulling) applied to the neck? Yes No Unknown
- 12) Were operative devices used to facilitate the birth? Yes No Unknown
Which type? Forceps Vacuum Extraction
If yes, were there any visible signs of injury to your baby? Yes No Unknown
If yes, where was the injury sustained? _____
- 13) Was there a birthing coach present? Husband, Doula, Friend, Other
- 14) At what week of pregnancy was your baby born? _____