

Pregnancy Chiropractic Intake Form

Primary Complaint:

What is your current concern? _____

Where do you feel discomfort? _____

How would you describe the pain? _____

(stabbing, dull, achy, stiff & tight, burning, pins and needles, etc.)

Does the pain travel to other parts of your body? _____

When did it occur? _____ How did it occur? _____

Is it getting better or worse, or staying the same? _____

Have you seen other health professionals for this concern? Yes No

If yes, whom, and what treatment did they use? _____

Have you taken medication for this complaint? Yes No

Have you ever experienced this complaint before?.... Yes No If yes, when? _____

Did you receive any treatment at the time for this complaint? Yes No

Have you had x-rays in relation to the current complaint?..... Yes No

Is this an injury that occurred at work?..... Yes No If yes, was it reported?..... Yes No

Is this an injury as a result of a motor vehicle accident?... Yes No If yes, is there a claim pending?..... Yes No

Have you seen a chiropractor previously? _____

If yes, when was your last treatment? _____

How far along into your pregnancy are you?

When is your baby's due date?

Have you experienced any trauma during this pregnancy?

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

Dates and Reasons:

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

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What type of birth care provider are you planning on using?

- Midwife OB/Gyn Medical Doctor Other

Where do you plan on delivering? _____

Is this your first pregnancy?..... Yes No

If not, how many pregnancies previously?_____

How many children do you have?_____

How many vaginal deliveries?_____

How many caesarian sections?_____

Have there been any complications during your previous deliveries?..... Yes No

Was labour induced/use of Pitocin?..... Yes No Unknown

Did your care provider rupture your membranes?..... Yes No Unknown

Was there any back pain during labour?..... Yes No

Did you receive an epidural?..... Yes No

Were there any operative devices used?..... Yes No Forceps Vacuum

Have you experienced any of the following symptoms during this pregnancy or a previous pregnancy?

- | | |
|---|---|
| <input type="checkbox"/> Nausea/"Morning Sickness" | <input type="checkbox"/> Pain down Posterior Leg (sciatica) |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Heartburn/Indigestion |
| <input type="checkbox"/> Carpal Tunnel (numbness in hands/fingers) | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Pins/Needles in the front side of your leg | <input type="checkbox"/> Swelling of Ankles, Legs and Feet |
| <input type="checkbox"/> Pain in your Pubic Bone | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Leg Cramps | <input type="checkbox"/> Facial Paralysis |
| <input type="checkbox"/> Breech Presentation | <input type="checkbox"/> Gestational Diabetes |
| <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Low/Mid Back Pain |

Are you interested in:

- Acute Pain Care: We can provide relief for the immediate pain you are feeling. It is important to remember that your body is constantly changing and adapting for the duration of your pregnancy and you are likely to experience a reoccurrence of this pain.
- Maintenance Care: We can provide ongoing care for the duration of your pregnancy to prevent your pain from getting worse if it returns.
- Wellness Care: We can ongoing care for the duration of your pregnancy to prevent your pain from getting worse if it returns, as well as prevent many other common conditions associated with pregnancy. Wellness care has also been shown to reduce labour times and intensity of pain for women who are adjusted on a regular schedule.