Pregnancy Health History Form

Patient Information

Name: ____

Birthdate_____/______/__________ Age__________ Marital Status: ☐ S ☐ M ☐ W ☐ D

Home Address:____

City__________________ State ______ Zip_________

Cell Phone: _______________________ Other Phone: ___________________________

Email ____

May we add you to our email newsletter? ☐ Yes ☐ No

Occupation ____

Who is your Primary Care Physician? ______________________________

Clinic Name_________________________ Date & Reason for last visit _______________________

May we communicate with your Primary Care Physician regarding your care if necessary?

☐ Yes ☐ No

Have you ever received Chiropractic Care? ☐ Yes ☐ No

If yes, who is your previous Doctor of Chiropractic? ______________________

What was the date and reason for previous visit? ______________________

Were you pleased with your care? ☐ Yes ☐ No

How did you find out about our office?______________________________

Emergency Contact

Name:__________________________ Relationship: ____________________

Phone:______________________ Alternate Phone: _______________________

Current Health Concerns

If there are no current concerns and this assessment is to ensure optimum health, function and wellness check here ☐

Otherwise, please describe any current health concerns_______________________________

____

About Your Pregnancy

Is this your first pregnancy? ☐ Yes ☐ No

If this is not your first, how many children do you have?__________

Have you had any complications with previous pregnancies? ☐ Yes ☐ No

If yes, please explain: ______________________________________

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? ____________ How many weeks along are you?_______

Baby Position (if known):______________________

Who is your primary care giver for delivery?

☐ Midwife ☐ Ob/gyn ☐ GP Name: _________________________

What is your planned location for delivery?

☐ Home ☐ Birthing Center ☐ Hospital ☐ Other

Any special arrangements for the birth?

☐Water Birth ☐ Birth Chair ☐ Squat ☐ Planned C-Section ☐ VBAC

☐ Other:____

Have you had any testing ?

☐ Genetic ☐ Blood ☐ Ultrasound ☐Amniocentesis

☐ Chorionic Villi Sampling ☐ Other:____

Dates/Reason:____

Was your blood pressure prior to pregnancy:

☐ Within normal range ☐ Low ☐ High

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

Have you smoked prior to/along with this pregnancy? ☐ Yes ☐ No ☐ Quit_______________

Have you had alcohol during this pregnancy? ☐ Yes ☐ No

How do you feel about this pregnancy?____

Have you noticed:

☐ Low Back Pain

☐ Sacrum/Tailbone Pain

☐ Pain radiating down leg/buttocks

Left or Right

☐ Pubic Bone Tenderness

☐ Headaches

☐ Arm/Leg Numbness/tingling

☐ Upper Back Pain

☐ Swelling in arms/legs

☐ Neck Pain

☐ Dizziness/Lightheadedness

☐ Constipation

☐ Heartburn

☐ Digestive Complaints

☐ Nausea/Vomiting

When or how often?____

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

Character of the pain:

☐ Sharp ☐ Dull ☐ Ache ☐ Burning ☐ Tingling ☐ Throbbing ☐ Spasms

☐ Other:____

When did you notice it?____

What happened? ____

What relieves the pain?____

What aggravates the pain?____

Does it radiate or cause problems elsewhere? ____

Any Associated or related concerns?____

Have you seen any other professional for this? (name)____

Treatment/Results:____

Other Health Concerns

Please note all other health concerns present or in the past. (Please Check all that apply)
Disease History:

☐ Allergies
☐ Appendicitis
☐ Arthritis
☐ Asthma
☐ Bleeding Disorders
☐ Bloating
☐ Bronchitis
☐ Cancer: _______________
☐ Cataracts
☐ Diabetes
☐ Difficulty Concentrating
☐ Difficult Digestion
☐ Other:____________________________________

☐ Emphysema
☐ Epilepsy
☐ Fatigue
☐ Frequent Colds
☐ Heart Disease
☐ High Blood Pressure
☐ Herniated Disc
☐ High Cholesterol
☐ Hypertension
☐ Hypoglycemia
☐ Indigestion
☐ Kidney Disease
☐ Liver Disease

☐ Diarrhea
☐ Loss of Balance
☐ Lowered Resistance
☐ Migraines/Headaches
☐ Multiple Sclerosis
☐ Nasal Congestion
☐ Runny Sinuses
☐ Thyroid Problem
☐ Tonsillitis
☐ Ulcers
☐ Ulcerative Colitis
☐ Urinary Tract Infection
☐ Vision Changes

Physical Stresses

Any injuries/falls/traumas during infancy or **childhood**? ☐ Yes ☐ No ☐ Unsure
If yes, please explain____
Any injuries/falls/traumas during **adulthood**? ☐ Yes ☐ No ☐ Unsure
If yes, please explain____
Any Vehicle Accidents? ☐ Yes ☐ No
If yes, please explain, dates____
Any Hospital visits? ☐ Yes ☐ No
If yes, please explain____
Have you had any surgeries or fractures? ☐ Yes ☐ No
If yes, please explain, 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____
Do you have a regular exercise routine?
____
Any fractured bones or dislocations? ☐ Yes ☐ No ____________________________________

Chemical Stresses

Are you taking prescription or over-the-counter medications? ☐ Yes ☐ No
If yes, please indicate what and why____
Are you currently taking supplements? ☐ Yes ☐ No
If yes, please indicate what and why____

Emotional/Mental 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 on a scale from 1 to 10 (1 being minimal stress, 10 being extreme):

- o Life in general_________
- o Work and Career_________
- o Relationships_________
- o Financial Stress_________
- o Time Management_________
- o Sports and Hobbies_________
- o Health and Well Being_________
- o Quality of Sleep_________
- o My Pregnancy_________

If you are experiencing significant or ongoing stress, please explain:_______________________________________
____

Do you practice any sort of meditation, breath work, or other mind-body movement or have a routine to reduce your stress? ☐ Yes ☐ No Explain:____

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
- ☐ Other: ____
- ☐ Kidney Disease
- ☐ Dementia
- ☐ Diabetes

Why Are You Here?

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

- ☐ Improvement in Function
- ☐ Pain Reduction
- ☐ Relief
- ☐ Improved Quality of Life
- ☐ Full Body Integration
- ☐ Optimal Baby Position
- ☐ Symptom Management
- ☐ Stress Reduction
- ☐ Keep Me Moving
- ☐ Optimum Function and Quality of Life
- ☐ Improved Performance
- ☐ Healthier Immune System
- ☐ Wellness
- ☐ Longevity

Please list any other goals you may have:____

Consent for examination and care once a report of 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 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 health care 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 the best practices delivered in my interests.

Name:____ Date:____

Signature:____

Doctor of Chiropractic:

Jessica Mitchell, D.C.
Mitchell Family Chiropractic
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Tacoma, WA 98406