Davis Family Chiropractic, PLLC

Pregnant Patient Information Form

Date: _____ Social Security Number: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____ Date of Birth: _____

Home Phone #: _____ Work #: _____ Cell #: _____

Are you: □ Single □ Married □ Divorced □ Separated □ Widowed

Patient Employer/School: _____ Occupation: _____

Spouse's or Parent's Name: _____ Spouse's Employer: _____

Whom may we thank for referring you? _____

Would you like to receive our monthly newsletters? □ No □ Yes Email? _____

Have you received previous Chiropractic care? □ No □ Yes Where? _____

Responsible Party:

Insurance Company: _____ Group #: _____

Subscriber's Name: _____ Date of Birth: _____

Relationship to Patient: _____ Name of Employer: _____

Prenatal History:

Is this your first pregnancy? □ Yes □ No How many other births have you had? _____

How many weeks pregnant are you? _____ When is your due date? _____/ _____/ _____

Name of Obstetrician or Midwife: _____

Where do you plan to deliver? □ Hospital □ Birthing Center □ Home

Have you experienced any traumas (accidents, falls) during this pregnancy? □ No □ Yes

Please describe: _____

Please list any medications taken during this pregnancy: _____

Position of Baby: □ Vertex (head down) □ Transverse (sideways) □ Breech (bottom or feet down)

Previous Birth History:

Place of birth: □ Hospital □ Birthing Center □ Home

Birth Care Provider: □ OB/GYN □ Midwife □ # of weeks delivered? _____

Labor Induced? □ No □ Yes What was used? □ Pitocin □ Prostaglandin gel □ Other

Did you experience any back pain during delivery? □ Yes □ No

Type of birth: □ Vaginal □ Forceps □ Vacuum □ Cesarean

Current Complaints:

Reason(s) for visit: □ Wellness Care □ Mid back □ Carpal Tunnel □ Sciatica □ Headaches
□ Low Back Pain □ Neck Pain □ Pubic Bone Pain □ Round Ligament Pain
□ Breech/Abnormal Position □ Other: _____

Date of Onset?_____

What caused the pain to start? Was it sudden or gradual? _____

What makes it better? _____ What makes it worse? _____

Describe the type of symptom: □Aching □Sharp □Dull □Numb □Tingling □Shooting □Burning

Difficult Activities: □Walking □Sitting □Lying Down □Standing □Bending

Rate the severity of your complaint: (1 mild and 10 severe) 1 2 3 4 5 6 7 8 9 10

How does this interfere with your daily life, work or home? _____

Health History Check only those conditions which are applicable

□ AIDS/HIV	□ Diabetes	□ Liver Disease	□TMJ Dysfunction
□Anorexia/Bulimia	□Emphysema	□ Migraine Headaches	□Rheumatoid Arthritis
□Arthritis	□Epilepsy	□Vertigo	□Carpal Tunnel Syndrome
□Asthma	□Fractures	□Multiple Sclerosis	□Thyroid Problems
□Bleeding Disorders	□Disc Problems	□Osteoporosis	□Allergy/Sinus Problems
□Female Complications	□Headaches	□Pacemaker	□Tumors/Growths
□Ear Infections	□Fibromyalgia	□Parkinson's Disease	□Chronic Fatigue Syndrome
□Prosthesis	□Heart Disease	□Bed Wetting	□Ulcers
□Cancer	□Herniated Disc	□Pinched Nerve	□Other _____
□Stroke	□High Cholesterol	□High Blood Pressure	_____
□Depression	□ADD/ADHD	□Stress	

Dates of Last Exams: _____

Please list any surgeries and the dates they occurred:_____

_____

Family History The following family members have the same or similar problem(s):

□Mother □Father □Brother □Sister □Spouse □Children

Have they received chiropractic care? □Yes □No Name of Chiropractor: _____

Daily Habits

What type of exercise do you perform on a daily basis? ☐None ☐Moderate ☐Heavy

What do your daily work habits include? ☐Sitting ☐Standing ☐Light ☐Heavy Labor ☐Computer Work

What vitamins do you currently take? _____

What other nutritional supplements do you take? _____

Do you smoke? ☐Yes ☐No # per day? _____ Coffee or caffeinated drinks? _____