Essential Family CHIROPRACTIC

PREGANCY PRACTICE MEMBER APPLICATION

Name: _____ Email Address: _____

Date of Birth: _____/_____/_____ Age: _____ Today's Date: _____/_____/_____

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____

Preferred Method of Communication (check one): □ Email □ Text □ Cell Phone □ Home Phone

Occupation: _____ Student / Full-Time Parent / Retired From: _____

Employer's Name: _____

Marital Status: S M D W Spouse's Name: _____ Number of Children: _____

Names, Ages & Gender: _____

CURRENT TRIMESTER? 1st □ 2nd □ 3rd □ **Current Gestation Week**:_____ **Expected Due Date**: _____

DOES YOUR FAMILY HAVE A PEDIATRICIAN? If yes, name and city _____

Who may we thank for referring you? _____

WHAT BRINGS YOU IN TODAY? PLEASE LIST YOUR HEALTH CONCERNS BELOW

General Health Concerns:	**Rate of Severity 1 = mild 10 = unbearable**	**When did this episode start?**	**If you had the condition before, when?**	**Did the problem begin with an injury?**	**Are symptoms constant or intermittent?**
1.					
2.					
3.					
4.					
5.					

HAVE YOU SEEN ANY MEDICAL DOCTORS FOR THE ABOVE CONDITIONS? YES / NO

IF YES, WHEN? _____

Pregnancy Concerns:	**Rate of Severity 1 = Mild, 10 = Severe**	**What Trimester did it Start?**	**Did you have this with previous pregnancies?**	**Is it constant or intermittent?**
1.				
2.				
3.				
4.				
5.				

PREVIOUS PREGNANCIES: **NUMBER OF PREGNANCIES** _____ **NUMBER OF BIRTHS** _____

1. DATE (mm/yy) _____ Delivered at _____ weeks □ VAGINAL □ V-BAC □ C-SECTION: Scheduled or Emergency
2. DATE (mm/yy) _____ Delivered at _____ weeks □ VAGINAL □ V-BAC □ C-SECTION: Scheduled or Emergency
3. DATE (mm/yy) _____ Delivered at _____ weeks □ VAGINAL □ V-BAC □ C-SECTION: Scheduled or Emergency
4. DATE (mm/yy) _____ Delivered at _____ weeks □ VAGINAL □ V-BAC □ C-SECTION: Scheduled or Emergency

WHICH OF THE FOLLOWING ARE YOU USING? Circle all that apply. OBSTETRICIAN DOULA MIDWIFE OTHER

DOCTOR/DOULA/MIDWIFE Name(s) _____

PHONE NUMBER _____ CITY _____

WHERE WILL YOU BE DELIVERING? HOSPITAL BIRTHING CENTER HOME BIRTH

BIRTHING CENTER/HOSPITAL NAME (if applicable): _____

LIST ALL OVER THE COUNTER & PRESCRIPTION MEDICATIONS THAT YOU HAD TO DISCONTINUE DURING PREGNANCY:

_____

_____

LIST ALL OVER THE COUNTER & PRESCRIPTION MEDICATIONS YOU CURRENTLY TAKE / LAST ROUND OF ANITBIOTICS (DATE):

_____

_____

HAVE YOU RECEIVED A FLU SHOT DURING THIS PREGNANCY? □ YES □ NO

LIST ALL TRAUMAS (AUTO ACCIDENTS, SLIPS, FALLS, SPORTS, EXERCISE) AND DATES:

Please indicate if the trauma was pre-pregnancy or during this pregnancy

_____

_____

WHEN WAS YOUR LAST AUTO ACCIDENT? _____

HAVE YOU EVER BEEN KNOCKED UNCONCIOUS? YES / NO **FRACTURED A BONE? YES / NO**

IF YES, PLEASE DESCRIBE: _____

_____

HAVE YOU PREVIOUSLY SEEN A CHIROPRACTOR? YES / NO **DATE OF LAST SPINAL XRAYS:** _____

IF YES, WHO AND WHEN WERE YOU LAST ADJUSTED? _____

LIST ALL SURGICAL OPERATIONS AND YEARS:

_____

_____

CIRCLE ANY CONDITION YOU HAVE NOW/ HAVE HAD:			
STROKE	**CANCER**	**HEART DISEASE**	**SPINAL SURGERY**
SEIZURES	**SPINAL BONE FRACTURE**	**SCOLIOSIS**	**DIABETES**

CIRCLE ALL *CURRENT* PROBLEMS YOU HAVE:

DIZZINESS/VERTIGO	TMJ / JAW PAIN	MID BACK PAIN	LOW BACK PAIN	DISC PROBLEMS
HEADACHES	SHOULDER PAIN	NUMBNESS IN ARMS	NUMBNESS IN LEGS	HIP/PELVIC PAIN
NECK PAIN	ARM PAIN	NUMBNESS IN HANDS	NUMBNESS IN FEET	SCIATICA
MUSCLE SPASMS	MUSCLE WEAKNESS	KNEE PAIN	LEG PAIN	SCOLIOSIS
NAUSEA	SINUS ISSUES	CHEST PAIN	MENSTRUAL CRAMPS	BLADDER PROBLEMS
ANXIETY	RINGING IN EARS	HEART DISORDERS	MENSTRUAL IRREGULARITY	PLANTAR FASCIITIS
DEPRESSION	THROAT ISSUES	HIGH/LOW BLOOD PRESSURE	INFERTILITY/MISCARRIAGE	SHORTNESS OF BREATH
NERVOUSNESS	THYROID ISSUES	ALLERGIES	KIDNEY PROBLEMS	FREQUENT COLDS
EPILEPSY/SEIZURES	EAR INFECTIONS	CHRONIC FATIGUE	ASTHMA	FIBROMYALGIA
ADD/ADHD	INSOMNIA	DIGESTIVE ISSUES	LIVER DISEASE	VISION CHANGES
ARTHRITIS	ECZEMA/RASH	ACID REFLUX/ULCERS	PROSTATE ISSUES	SWELLING IN JOINTS

SOCIAL HISTORY | DO YOU…

EXERCISE? YES / NO HOW OFTEN? _____ MILD / MODERATE / INTENSE

WHAT TYPES OF EXERCISE? _____

SMOKE? YES / NO HOW OFTEN? _____

DOES ANYONE IN YOUR HOUSEHOLD SMOKE (CURRENTLY OR HAVE QUIT RECENTLY**)?** □ YES □ NO

HOW DO YOUR CURRENT PROBLEMS AFFECT YOUR FAMILY LIFE, WORK, HOBBIES, ETC?

_____

_____

WHAT IS YOUR BIRTH PLAN FOR THIS PREGNANCY?

_____

_____

_____

_____

WHAT ARE YOUR HEALTH GOALS? HOW WILL YOUR LIFE CHANGE ONCE ATTAINED?

_____

_____

_____

BIRTH & CHILDHOOD HISTORY

How were you (the patient) born?

Any complications during your birth process or mother's pregnancy?	**YES / NO**	Details:		
Type of birth:	**C-Section**	**Vaginal**	How long was labor and delivery?	
What did the care provider use to assist in delivery?	**Hands**	**Vacuum**	**Forceps**	**Unassisted**
Were you vaccinated?	**YES / NO**	List any reactions/injuries (ex: fever):		
Did you have any early health challenges?	**YES / NO**	Details:		
Did you have any concerning trips or falls?	**YES / NO**	Details:		
List any over-the-counter or prescription medications frequently used as a child	**YES / NO**	Details:		
Did your parents worry often about your health?	**YES / NO**	Due to health issues, did you miss school and other activities?	**YES / NO**	Details:

Circle all symptoms you experienced as a child:

Trouble Sleeping	**Ear Infection**	**Colic/Reflux**	**Allergies**	**Abnormal Skull Shape**
Frequent Tantrums	**Bedwetting**	**Fevers**	**ADHD**	**Trouble Concentrating**
Weak Heartbeat	**Racing Heart**	**Murmur**	**Torticollis**	**Digestive Problems**
Breathing Problems	**Birth Trauma**	**Seizures**	**Asthma**	**Known Vaccine Reaction**

Other:_____

FAMILY HISTORY

CONDITION	MOTHER	FATHER	CHILDREN	SPOUSE
Arthritis				
Asthma/Allergies/Sinus Trouble				
ADD/ADHD				
Bed Wetting				
Cancer				
Carpal Tunnel				
Deceased				
Diabetes				
Digestive Problems/Heartburn				
High Blood Pressure				
Ear Infections				
Fibromyalgia				
Headaches/Migraines				
Neck Pain/Back Pain/Disc Problems				
Menstrual Problems				
Scoliosis				
TMJ				