Sleigh Family Chiropractic:
A Creating Wellness
Center

Pregnancy Health History

Name:_____

What You Prefer to Be Called: _____

❑ Male ❑ Female Birth Date:___/___/___ Age:_____ SS#:__ __ __ - __ __ - __ __ __ __

Address:_____ Apt. #:_____

City:_____State:_____ Zip Code:_____

Please circle the phone number(s) that is(are) the best to contact you:

Cell: ( )_____ Home: ( )_____

❑ I would like to opt out of receiving SMS messages and appointment reminders. I understand that Sleigh Family Chiropractic will no longer be able to communicate with me through SMS text messaging.

Email Address:_____

Employer: _____ Occupation:_____

Marital Status: ❑ married ❑ single ❑ divorced ❑ widowed

Spouse's Name:_____ Occupation:_____

Children's Names and Ages: _____

_____

Family Doctor's Name:_____ Phone:( )_____

Your Birth Care Provider's Name: _____ Phone:( )_____

Referred By:_____

PAYMENT INFORMATION:

If you have insurance that may cover chiropractic services, please provide your current insurance card so that we may make a copy. Additionally, please enter the following information relating to the person who is responsible for the insurance coverage.

Insured's Name:_____ Insured's Birth Date: _____

Insurance Company:_____ Insured's ID:_____

❑ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered.

Current Condition

Have you had previous chiropractic care? When? _____

Reason for visit_____

When did your symptoms appear?_____

How did this condition develop? (fall, accident, gradual, sudden, etc) _____

Is your condition getting worse over time?_____ Have you had the same/similar problems before?_____

Have you seen other doctors for this complaint?_____ Type of Doctor(s):_____

What percent of awake hours does it affect you? less than 25% ____ 25% ____ 50% ____ 75% ____ 100% ____

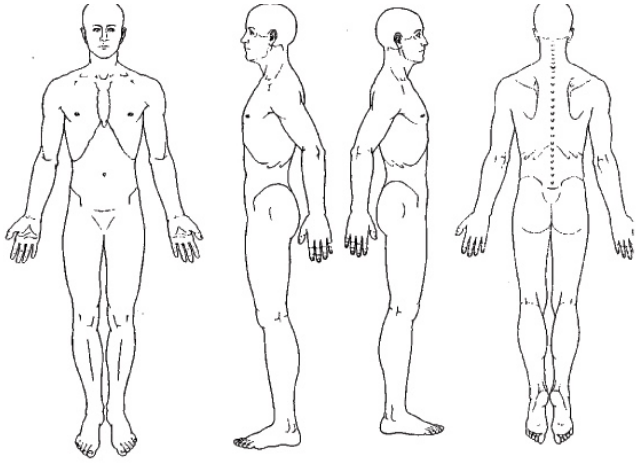
Does it interfere with your: ( ) work ( ) sleep ( ) daily routines ( ) recreation ( ) other _____

Activities which are painful: ( ) standing ( ) sitting ( ) lying down ( ) walking ( ) bending ( ) other _____

Type of pain: ( ) sharp ( ) dull ( ) throbbing ( ) numbness ( ) aching ( ) shooting ( ) burning ( ) tingling ( ) cramps ( ) stiffness ( ) swelling

Pain Location

Please circle or mark with an X, the areas of complaint on the diagram below.



Health History

Please mark with an X to indicate if you have any of the following diseases/medical conditions.

If condition happened in the past, please indicate by marking with a "P".

AIDS/HIV ( )
Alcoholism ( )
Allergy Shots ( )
Ankle/Foot Pain ( )
Anemia ( )
Anorexia ( )
Appendicitis ( )
Arthritis ( )
Artificial Bones/Joints ( )
Asthma ( )
Bleeding disorders ( )
Breast Lump ( )
Bronchitis ( )
Bulimia ( )
Cancer ( )
Cataracts ( )
Chemical dependency ( )
Congenital Heart Defect ( )
Diabetes ( )
Difficulty Breathing ( )
Diverticulosis ( )
Dizziness ( )
Ear Problems ( )
Emphysema ( )
Epilepsy ( )
Fractures ( )
Gall Stones ( )
Glaucoma ( )
Goiter ( )
Gout ( )
Headaches (frequent) ( )
Heart Attack ( )
Heart Disease ( )
Heart Murmur ( )
Hepatitis ( )
Hernia ( )
Herniated Disc ( )
High Cholesterol ( )
High/Low Blood Pressure ( )
Hip/Leg Problems ( )
Irritable Bowel Syndrome ( )
Jaw Problems ( )
Kidney disease/problems ( )
Knee Pain ( )
Liver disease/problems ( )
Lower Back Pain ( )
Menstrual Problems ( )
Mid Back/Rib Pain ( )
Migraines ( )
Miscarriage ( )
Mitral Valve Prolapse ( )
Multiple Sclerosis ( )
Neck Pain ( )
Osteoporosis ( )
Pacemaker ( )
Parkinson's ( )
Pelvic Pain ( )
Polio ( )
Prostate problems ( )
Psychiatric Care/Problems ( )
Rheumatic Fever ( )
Sciatica ( )
Scoliosis ( )
Seizures ( )
Shingles ( )
Shoulder/Arm Problem ( )
Sinus Problems ( )
Stomach Problems ( )
Stroke ( )
STD ( )
Suicide attempts ( )
Thyroid problem ( )
Tonsillitis ( )
Tuberculosis ( )
Tumors ( )
Ulcers ( )
Whiplash ( )
Wrist/Elbow/Hand Pain ( )

Please list any other medical condition(s) you have: _____

_____

Please list ALL medications that you are taking (prescription and non-prescription): _____

_____

Are you under the care of any other healthcare provider or doctor? ❑ Yes ❑ No

If yes, please provide name(s) and type(s) of doctor: _____

Please list anything that you may be allergic to: _____

_____

Please list all previous surgeries/treatments with dates: _____

_____

Please list any and all accidents with dates (car accidents, falls, broken bones, concussions, etc.):

_____

_____

How would you rate your diet? ( ) Excellent ( ) Good ( ) Fair ( ) Poor

Do you exercise regularly? ❑ Yes ❑ No If yes, How much? _____ times/week How long? _____

Are you wearing: ❑ Heel lifts ❑ Sole lifts ❑ Custom orthotics ❑ Arch supports

What is the age of your mattress? _____ **Is it comfortable?** ❑ Yes ❑ No

Work Habits: ( ) sitting ( ) standing ( ) repetitive bending ( ) light labor ( ) heavy labor ( ) other _____

Pregnancy Specific Questions:

How many weeks pregnant are you? _____ Date of Missed Period?_____

How many pregnancies have you had?_____ Miscarriages?_____ Abortions?_____

Have you had any traumas (accidents, falls) during this pregnancy? If yes, please describe: _____

_____

Please list any medications taken during this pregnancy? _____

Have you ever had surgery in the genital region?____ If yes, describe: _____

Any history of large babies in your or the baby's father's family or in previous pregnancies? ❑ Yes ❑ No

Do you smoke or drink alcohol? ❑ Yes ❑ No Do you have a birth plan? ❑ Yes ❑ No

Will your birth be (circle): with a midwife with an OB with a doula undecided

Where do you plan on delivering? _____

Are you OK with the use of the following (circle): epidural pitocin vaccinations at birth ultrasounds

Are you taking a childbirth education class? (hospital, hypnobirthing, Bradley Method) _____

How many ultrasounds have you had? _____

Describe your diet:_____

_____

<u>Pregnancy Emotions</u>

How did you feel when you found out you were pregnant? _____

What is your current living situation? (I.e. Married, Single, other children at home, smokers)_____

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

_____

How many hours per day would you say you spend connecting with your baby? (talking to him/her, singing, etc.) _____

Rate your stress on a scale of 1-10 _____

<u>Previous Birth History (if multiple, please answer questions taking into consideration all previous experiences)</u>

Place of birth: _____ Delivering Practitioner (cirlce): OB/Gyne Midwife

Position of delivery: on back w/ feet up on side kneeling squatting other

Was labor induced? If yes, what type _____ Were your membranes ruptured by your provder? ❑ Yes ❑ No

Did you receive pain medications/anesthesia? If yes, what type _____ Did you delivery vaginally? ❑ Yes ❑ No

What was the presentation of the baby at the time of delivery? Normal Posterior Breech Facial Brow

Were operative devices used at birth? ❑ Yes ❑ No If yes, (circle) forceps vacuum Was there injury to the baby? ❑ Yes ❑ No

❖ We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.

❖ Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the service and no financial arrangements have been made, you will be responsible for any expenses incurred in collecting your account.

❖ I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

❖ I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

Signature _____ Date _____/_____/_____