

Pregnancy Health History

Welcome to Family First Chiropractic

Name _____
Address _____
City _____ Prov _____ PC _____
Phone: (H) _____ (W) _____
E-mail _____
Date of Birth _____ (Age _____)
Referred By _____

Occupation _____
Employer _____
Marital Status _____ S _____ M _____ D _____ W _____
Spouse's Name _____
No. of children _____ Due Date _____
Manitoba Health registration # _____
MD's Name _____

Chiropractic History

Have you previously seen a chiropractor? Yes No Reason _____ Did they take x-rays? Yes No
If yes, when was your last visit and how long did you receive care _____

Birth Information

Who are your chosen birth attendants? Midwife Obstetrician Doula Chiropractor
Name of birth attendants: _____ Date of last visit: _____
Chosen Location of Birth: Hospital Birthing Center Home
Planned maternity leave? Yes No If so, starting when? _____
How active is your baby? Not moving at all slow but moving active very active other _____
If you have had a previous pregnancy did you have or experience any of the following with your labour:
Hospital birth home birth birthing centre birth Other birth location Epidural episiotomy induction
breach presentation back labour forceps c-section vacuum extraction fetal scalp monitoring

Current Health Condition:

Reason for today's visit: _____ Pain or problem started on: _____
Pain is: Sharp Dull Constant Intermittent Pain is interfering with: Work Sleep Routine Other _____
What makes/when is it worse? _____ What makes/when is it better? _____

Other symptoms:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Fainting | <input type="checkbox"/> Ear Infections |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Frequent colds/flu |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Menstrual problems |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Feet Cold | <input type="checkbox"/> IBS / Crohn's disease |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Depression | <input type="checkbox"/> Hands Cold | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Stomach Upset | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Constipation | <input type="checkbox"/> Other Conditions or diseases _____ |
| <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Ears Ring | <input type="checkbox"/> Loss of Balance | |
| <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Fever | <input type="checkbox"/> Buzzing in Ear | |

Accidents/Trauma/Injury History

Number of car accidents: _____ Approximate dates: _____
Any work, sports or other injuries: _____
Any medications you are currently taking: _____
Have you had surgery? Yes No What type? _____ When? _____
Any significant family medical conditions/history: _____
Give a brief description of the physical nature of your work: _____
Rate your occupational stress (1-10, 10 being the most stressful) _____
What types of physical, emotional and chemical stressors have you experienced _____

As a result of my chiropractic care, I would like to: (Please check all that apply)

- Feel better quickly Have a healthier spine Live a healthier lifestyle Have a healthier body by keeping my nervous system healthy

Signature _____

Date _____