Chiropractic - Pregnancy

File #: ______________________________

Date: _______________________________

Waterdown Village Chiropractic & Wellness Group

255 Dundas Street East
Unit #14A
Waterdown, ON L8B 0E5
T 905·689·4440
F 905·689·4441
E info@wvchirogroup.ca

wvchirogroup.ca

General Information

How do you wish to be addressed in our office?

☐ First name ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr.

How do you wish to be contacted by our office regarding your appointments?

☐ Email ☐ Phone

Last Name: ______________________________ **D.O.B.** ______________________

First Name: ______________________________ **Sex:** ☐ M ☐ F

Address: ____

Town/City: ____________________ **Province:** __________ **Postal Code:** ______________

Home Phone: ( ) ______________ **Cell Phone: ( )** ____________________

Email: ____________________________

______________ Please Initial **Consent to receive email communication from the clinic**

Occupation: ______________ **Spouse's name (if applicable):** ______________________

Children: Y N **Number:** ____________ **Ages:** ________________________

(Females) Are you pregnant? Y N **How many weeks?** _______ **Estimated Due Date:** ____________

Family Dr. Name: ______________________ **Phone: ( )** ______________________

Previous Wellness Care? (check all that apply)

☐ Chiropractic ☐ Physiotherapy ☐ Naturopathy ☐ Massage Therapy ☐ Osteopathy

Location: ____

Referred by: ____

How did you decide to choose our office? ____________________________________

Reason for consulting the office:

- ☐ I have a specific problem and require help only with this problem.
- ☐ After my specific problem has been relieved, I am interested in strategies for maintenance.
- ☐ After my specific problem has been resolved and I understand methods to ensure it does not return, I am interested in strategies to improve my general health.
- ☐ I have no symptoms and I feel well. I am interested in strategies to help me to continue to feel well, or even better.

Expressed consent to receive email

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Health History

The following health history is designed to uncover all areas of ill health. As the human body is designed to be healthy, any deviation from optimal health will reduce your body's wellness potential. A detailed history can give your chiropractor valuable insight into the wellness condition of your body prior to your pregnancy. Your health history includes your journey from childhood to present. Please take the time to fully complete this form to the best of your ability:

A. Growth and Development

Y N **To your knowledge, were there any difficulties or interventions employed at your own birth? (difficult delivery, forceps, vacuum extraction, epidural, c-section)**

Explain: ____

Y N **To your knowledge, did you ever experience a fall (out of bed, off a change table, table etc.) as an infant/toddler?**

Explain: ____

Y N **Childhood Illnesses? Details:** ______________________________

Y N **Childhood Accidents? (include sports injuries, slips and falls, etc.)**

Explain: ____

Y N **Did you ever play contact sports?**

Y N **Have you ever been told you have a scoliosis?**

Y N **Any other childhood traumas?**

Explain: ____

Y N **Were you vaccinated as a child?**

File #: ________________

B. Current Health Status

Y N **Have you had any past surgeries? If so, what?:** ____

____

Y N **Do you smoke?**

Y N **Have you smoked in the past? Date quit:** ____

Y N **Do you drink any alcohol? If so, how much/week?** ____

Y N **Do you feel that you have an adequate diet, especially vegetables?**

Y N **Have you ever been in a motor vehicle collision (include minor ones)?**

Explain: ____

Y N **Have you had any other accidents, trauma or fractures?**

Explain: ____

Y N **Previously diagnosed medical conditions? List:** ____

____

Y N **Does your job and/or daily activities require that you do a lot of twisting?**

Y N **Drugs / Prescription / Over the Counter / Recreational / Birth Control**

If yes, list drug and condition: ____

____

Y N **Dental problems?**

Explain: ____

Y N **Hearing problems?**

Explain: ____

Y N **Regular Exercise?** **Aerobic** **Non-Aerobic** _______ **x/week**

Stress: **Occupational** _________ **Physical** ______________ **Mental** ______________

Sleeping Posture: **Back** ___________ **Front** ___________ **Side** _____________

Hours of sleep per night on average: _________ **/Night**

File #: _________________

C. Health Symptoms

Health symptoms often appear after years of underlying dysfunction and/or in pregnancy. Please briefly describe any current painful symptoms you are experiencing:

____

____

How long ago did the problem start? ____

Did you have the problem prior to your pregnancy? Y N

The pain you experience is: CONSTANT OCCASIONAL

What aggravates your pain or problem? ____

What relieves your pain or problem? ____

Does your pain radiate or travel to other parts of your body? Y N

Does your condition get worse at certain times of the day or night? ______________________________

How long does the pain last when you get the pain? ____

Is your condition: **WORSENING** **IMPROVING**

Have you consulted other health professionals regarding this problem? Y N

If yes, which ones? ____

Have you taken any medications for this problem? Y N

If yes, what medication and for how long? ____

Family History of:

Other: ____

File #: ________________

D. Other Symptoms

Please check a box if you currently experience or have experienced any of these in the past:

- ☐ Headaches
- ☐ Neck pain
- ☐ Back pain
- ☐ Sleeping problems
- ☐ Stress
- ☐ Irritability
- ☐ Chest pains
- ☐ Dizziness
- ☐ Stiff neck
- ☐ Pins & needles in legs
- ☐ Pins & needles in arms
- ☐ Numbness in fingers
- ☐ Painful menstruation
- ☐ Numbness in toes
- ☐ Shortness of breath
- ☐ Fatigue
- ☐ Depression
- ☐ Memory loss
- ☐ Ringing in ears
- ☐ Ear infections
- ☐ Heart trouble
- ☐ Circulation problems
- ☐ Loss of balance
- ☐ Fainting
- ☐ Loss of smell
- ☐ Stroke
- ☐ Loss of taste
- ☐ Diarrhea
- ☐ Stomach upset
- ☐ Abdominal pain
- ☐ Constipation
- ☐ Cold sweats
- ☐ Fever
- ☐ Prostate problems
- ☐ Hepatitis B
- ☐ HIV
- ☐ Trouble with bowel or bladder control
- ☐ Reproductive problems (endometriosis, fibroids, impotence, etc.)

Expectations:

Please list your top 3 expectations that you have regarding your care at Waterdown Village Chiropractic & Wellness Group:

1. ____

2. ____

3. ____

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Extra Doctor's Notes

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Practitioner