Touch of Health Chiropractic:
A Creating Wellness Center

# PREGNANCY HEALTH INTAKE

## Personal Information

NAME: _____ SSN #: _____ AGE: _____ DATE: _____
ADDRESS: _____
CITY / STATE / ZIP: _____
HOME PHONE #: _____ WORK PHONE#: _____ CELL#: _____
E-MAIL ADDRESS: _____ MALE ☐ FEMALE ☐
BIRTH DATE: _____ BEST TIME & NO. TO CONTACT: _____
OCCUPATION: _____ EMPLOYER'S NAME AND ADDRESS: _____
SINGLE: ☐ MARRIED: ☐ DIVORCED: ☐ WIDOWED: ☐
NO OF CHILDREN: _____ NAMES, AGES AND GENDER: _____
_____
_____
WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

## Previous Chiropractic Care

Have you ever received chiropractic care? ☐ Yes ☐ No When was your last visit? _____
Reason for ending care? _____ How often were your sessions? _____
Do your partner and/or children currently receive chiropractic care? ☐ Yes ☐ No Have they ever? ☐ Yes ☐ No
Are you interested in learning about pediatric chiropractic care? _____

## Current Health Conditions

### Addressing what brought you to this office

If you have no symptoms or complaints and are here for **Chiropractic Wellness Services**, please skip to the "**General History**." (next page) Others, please briefly describe your chief concern, including the effect it has had on your life.

_____
_____

| Health Concerns: List health concerns according to their severity | Rate of Severity 1= mild 10= worst imaginable | When did this episode start? | If you had the condition before, when? | Did problem begin with an injury? | Are symptoms constant or Intermittent |
|---|---|---|---|---|---|
| 1. _____ | _____ | _____ | _____ | _____ | _____ |
| 2. _____ | _____ | _____ | _____ | _____ | _____ |
| 3. _____ | _____ | _____ | _____ | _____ | _____ |
| 4. _____ | _____ | _____ | _____ | _____ | _____ |

If you are experiencing pain, is it… ☐ Sharp ☐ Dull Ache
Does the pain travel/radiate anywhere: ☐ No ☐ Yes – please describe
Since the problem started, it is… ☐ About the same ☐ Getting Better ☐Getting Worse

What makes it worse? _____
What have you done for this condition that has helped you feel better? _____
_____
What have you done for this condition that was of no help? _____
_____

☐ I do ☐ do not have a family history of this or similar symptoms (If you do, please explain)

_____

_____

Is this condition interfering with your: ☐ Work ☐ Leisure ☐ Sleep ☐ Sports/exercise/walking, ☐ Positive mental attitude ☐ Hobbies ☐ Other _____

Have you had to, or felt the need to make any "positive" changes in your life due to your condition? (i.e., eat better, less alcohol or drugs, meditate, less destructive sports, activities, etc.) if so what?

_____

_____

## Previous Birth Experience

Is this your first pregnancy? ☐ Yes ☐ No # weeks: _____ Probable due date: ____/____/____
How many pregnancies have you had (excluding present one?) _____
How many live births? _____ Delivered at? _____

Did you have any complications or difficulties? ☐ Yes ☐ No _____

Did you see a chiropractor during your pregnancy? ☐ Yes ☐ No

| | Pregnancy #1 | Pregnancy #2 | Pregnancy #3 | Pregnancy #4 | Pregnancy #5 |
|---|---|---|---|---|---|
| Morning Sickness | ☐ | ☐ | ☐ | ☐ | ☐ |
| Good Health Habits | ☐ | ☐ | ☐ | ☐ | ☐ |
| Poor Health Habits | ☐ | ☐ | ☐ | ☐ | ☐ |
| Exercise During Pregnancy | ☐ | ☐ | ☐ | ☐ | ☐ |
| Baby Position Issues | ☐ | ☐ | ☐ | ☐ | ☐ |
| Back Pain | ☐ | ☐ | ☐ | ☐ | ☐ |
| Pubic Symphysis Pain | ☐ | ☐ | ☐ | ☐ | ☐ |
| Hours of Labor | _____ | _____ | _____ | _____ | _____ |
| # Weeks Born | _____ | _____ | _____ | _____ | _____ |
| Home Birth | ☐ | ☐ | ☐ | ☐ | ☐ |
| Vaginal | ☐ | ☐ | ☐ | ☐ | ☐ |
| C-Section | ☐ | ☐ | ☐ | ☐ | ☐ |
| Elected | ☐ | ☐ | ☐ | ☐ | ☐ |
| Emergency | ☐ | ☐ | ☐ | ☐ | ☐ |
| VBAC | ☐ | ☐ | ☐ | ☐ | ☐ |
| Forceps | ☐ | ☐ | ☐ | ☐ | ☐ |
| Vacuum Extract | ☐ | ☐ | ☐ | ☐ | ☐ |
| Traumatic Birth | ☐ | ☐ | ☐ | ☐ | ☐ |
| Tearing | ☐ | ☐ | ☐ | ☐ | ☐ |
| Breastfed | ☐ | ☐ | ☐ | ☐ | ☐ |
| -Until | ___ wks | ___ wks | ___ wks | ___ wks | ___ wks |
| Mastitis | ☐ | ☐ | ☐ | ☐ | ☐ |
| Formula Fed | ☐ | ☐ | ☐ | ☐ | ☐ |
| -Until | ___ wks | ___ wks | ___ wks | ___ wks | ___ wks |
| Trouble Feeding From | L/R | L/R | L/R | L/R | L/R |

## Conception & Early Pregnancy

Did you have any difficulty conceiving? ☐ Yes ☐ No
If yes, please explain _____
_____

Was this pregnancy planned? ☐ Yes ☐ No How do you feel about this pregnancy? _____

Have you experienced morning sickness? ☐ Yes ☐ No
If yes, please explain _____
_____

What was your pre-pregnancy weight? _____ Current weight? _____

Have you changed your diet/menu since learning of your pregnancy? ☐ Yes ☐ No

Would you like further information on healthy nutrition for pregnancy? ☐ Yes ☐ No

Have you smoked prior to or along with this pregnancy? ☐ Yes ☐ No

Have you had alcohol during this pregnancy? ☐ Yes ☐ No
Position of baby: Head Down: _____ Posterior: _____ Breech or Malposition: _____
Date of confirmed by palpation: _____ or Ultrasound: _____

## Your Birth Plan

Your top three goals for this pregnancy

1. _____
2. _____
3. _____

Do you currently have a birth plan? ☐ Yes ☐ No Would you like information on creating one? ☐ Yes ☐ No
If yes, please explain:

_____
_____
_____

Midwife _____ OB _____ Doula _____

Are you planning a: ☐ Home Birth ☐ Birth Center Birth ☐ Hospital Birth ☐ C-Section ☐ VBAC

Are you taking a childbirth preparation class? ☐ Yes ☐ No _____

Do you wish to have a natural vaginal labor and delivery? ☐ Yes ☐ No
If not, what concerns do you have? _____

Have you had any evaluation procedures (ultrasound, amniocentesis, chorionic villus sampling)? ☐ Yes ☐ No
If yes, please list dates, frequency and reasons: _____
_____

## Your Post-Birth Plan

Do you plan on breastfeeding your child? ☐ Yes ☐ No

Would you like further information on the advantages of breastfeeding? ☐ Yes ☐ No
What do you intend to do for vaccines? _____

Were you told you had a choice in vaccinating your child? ☐ Yes ☐ No

Would you like information on the “other side” of the issue? ☐ Yes ☐ No
Is there anything else you’d like to tell us about your pregnancy or birth plan?

_____
_____
_____

What would you like to gain from chiropractic care during your pregnancy?

_____
_____
_____

# Webster Technique Agreement

□ I acknowledge that the Webster Technique is a specific chiropractic analysis and diversified adjustment. The goal of the adjustment is to reduce the effects of sacral/pelvic subluxation and/or SI joint dysfunction. In doing so neuro-biomechanical function in the pelvis is improved.

□ I acknowledge that in a theoretical and clinical framework of the Webster Technique in the care of pregnant women, sacral subluxation may contribute to difficult labor for the mother (i.e., dystocia). Difficult labor is caused by inadequate uterine function, pelvic contraction, and baby malpresentation. The correction of sacral subluxation may have a positive effect on the causes of difficult labor.

□ I acknowledge that sacral misalignment may contribute to these primary causes of difficult labor via uterine nerve interference, pelvic misalignment and the tightening of specific pelvic muscles and ligaments. The resulting tense muscles and ligaments and their abnormal effect on the uterus may prevent the baby from comfortably assuming the best possible position for birth.

□ I understand that this sacral/pelvic analysis and adjustment may be used on all weight bearing spines: male, female, pregnant or not pregnant.

□ I acknowledge that this is not a breech turning or in utero-constraint technique

By signing this form, I understand the purpose of the Webster Technique and I agree to have the doctor perform the technique on me at her discretion.

Name _____ Date _____

I consent to a professional and complete chiropractic examination. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Signature_____ Date: _____

Thank you for filling out this form. It is your first step to **Creating Wellness!**
Return this to one of our team members and someone will be right with you.