Pregnancy Questionnaire

1. CONFIDENTIAL PATIENT INFORMATION:

First Name: _____ Last Name: _____ Preferred Name: _____

Date of Birth: _____ Gender: ○ M ○ F ○ Other SS #: _____

Marital Status: ○ S ○ M ○ D ○ W # of Children: _____

Occupation: _____ Street Address: _____ Apt./Unit #: _____

City: _____ State: _____ Zip Code: _____ Height: _____

Weight: _____ Email: _____

Cell Phone: _____ Other Phone: _____

Emergency Contact: _____ Emergency Relation: _____ Emergency Phone: _____

2. How did you hear about us?

☐ Current Patient (List who) _____

☐ Professional Referral/Doctor (List who) _____

☐ Google Search _____

☐ Facebook _____

☐ Community Partner (List who) _____

☐ Other (Specify) _____

3. Who is you primary care physician?

_____ Date of your last visit: _____

Reason for your last doctor visit: _____

4. Are you also receiving care from any other health professionals?

○ Yes ○ No

5. If yes, please name them and their specialty:

	Name	Specialty
1		
2		
3		

6. Please note any significant family medical history:

CURRENT HEALTH CONDITIONS

7. What health condition(s) bring you into our office?

8. Have you received care for this problem before?

- ○ Yes
- ○ No

9. If yes, please explain:

10. When did the condition(s) first begin?

11. How did the problem start?

- ○ Suddenly
- ○ Gradually
- ○ Post-Injury

12. Is this condition:

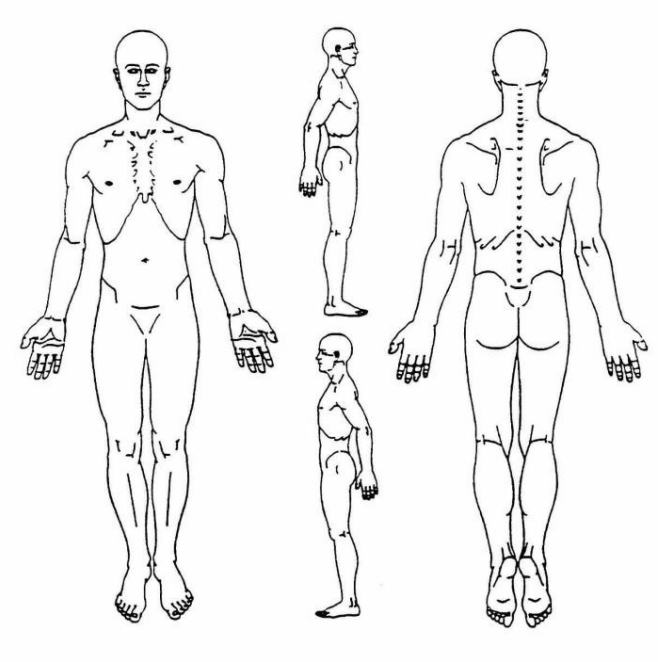
- ○ Getting worse
- ○ Improving
- ○ Intermittent
- ○ Constant
- ○ Unsure

13. What makes the problem better?

What makes the problem worse?

14. Please indicate where you are experiencing pain or discomfort.

0 - Painful 1 - Tender 2 - Sharp 3 - Ache 4 - Numbness/Tingling



YOUR HEALTH GOALS

15. Your top three health goals:

1.

2.

3.

CHIROPRACTIC HISTORY

16. What would you like to gain from chiropractic care?

○ Resolve existing condition(s) ○ Overall wellness ○ Both

17. Have you ever visited a chiropractor?

- ○ Yes
- ○ No

If yes, what is their name?

_____

18. What is their specialty?

- ○ Pain Relief
- ○ Physical Therapy & Rehab
- ○ Nutritional
- ○ Subluxation-based
- ○ Other

If other, specify:

_____

19. Do you have any health concerns for other family members today?

_____

_____

_____

_____

TRAUMAS: Physical Injury History

20. Have you ever had any significant falls, surgeries or other injuries as an adult?

- ○ Yes
- ○ No

21. If yes, please explain:

_____

_____

_____

_____

22. Notable childhood injuries?

- ○ Yes
- ○ No

23. If yes, please explain:

_____

_____

_____

_____

24. Youth or college sports?

○ Yes ○ No

25. If yes, list major injuries:

_____

_____

_____

_____

26. Any auto accidents?

○ Yes ○ No

27. If yes, please explain:

_____

_____

_____

_____

28. Do you have an open claim in regard to the car accident?

○ Yes ○ No ○ Not Yet

29. Exercise Frequency?

○ None ○ 1-2x per week ○ 3-5x per week ○ Daily

What types of exercise?

_____

30. How do you normally sleep?

○ Back ○ Side ○ Stomach

31. Do you wake up:

○ Refreshed and ready ○ Stiff and tired

32. Do you commute to work?

○ Yes ○ No

If yes, how many minutes per day?

_____

33. List any problems with flexibility. (ex. Putting on shoes/socks, etc.)

_____

_____

_____

_____

34. How many hours per day you typically spend sitting at a desk or on a computer, tablet or phone?

TOXINS: Chemical & Environmental Exposure

35. Please rate your CONSUMPTION for each:

	None - 1	2	Moderate - 3	4	5 - High
Alcohol					
Water					
Sugar					
Dairy					
Gluten					
Processed Foods					
Artificial Sweeteners					
Sugary Drinks					
Cigarettes					
Recreational Drugs					

36. Please list any drugs/medications/vitamins/herbs/other that you are taking, and why.:

	Medication Name	Dosage	Frequency	Reason for Taking
1				
2				
3				

THOUGHTS: Emotional Stresses & Challenges

37. Please rate your STRESS for each:

	None - 1	2	Moderate - 3	4	5 - High
Home					
Work					
Life					
Money					
Health					
Family					

Pregnancy Questionnaire

38. Previous Birth Experience:

Is this your first pregnancy?

○ Yes ○ No

39. If not, please tell us about your previous pregnancy and/or birth experience(s). (Duration, interventions, etc.)

_____

_____

_____

_____

40. Do you plan to follow the same plan as you previous delivery?

○ Yes ○ No

41. If no, what would you like to change?

_____

_____

_____

_____

Conception & Early Pregnancy

42. When is your expected or calculated due date?

_____

43. Did you have difficulty conceiving?

○ Yes ○ No

44. If yes, please explain:

_____

_____

_____

_____

45. Have you ever used any form of hormonal or oral contraceptives?

○ Yes ○ No

46. If yes, which ones and for how long?

_____

47. When was you last menstrual cycle? _____

What was your pre-pregnancy weight? _____

Current weight? _____

48. Have you experienced morning sickness?

○ Yes ○ No

49. If yes, please explain:

_____

_____

_____

_____

Current Health Conditions

50. What type of exercise(s) are you currently performing?

_____

51. Please tell us about your current diet, and dietary restrictions.

_____

_____

_____

_____

52. Have you taken any medications or supplements during your pregnancy?

○ Yes ○ No

53. If yes, please explain:

_____

_____

_____

_____

54. Have you had any slips, falls, or other physical traumas during the pregnancy?

○ Yes ○ No

55. If yes, please explain:

_____

_____

_____

_____

56. Have you had any major emotional stressor during your pregnancy?

○ Yes ○ No

57. If yes, please explain:

_____

_____

_____

_____

Your Birth Plan

58. Your top three goals for this pregnancy:

1. _____

2. _____

3. _____

59. Do you currently have a birth plan?

○ Yes ○ No

60. If yes, please explain:

_____

_____

_____

_____

61. Are you taking any pre-natal or birthing classes?

○ Yes ○ No

62. If yes, please explain:

_____

_____

_____

_____

63. Who is your OB/GYN or midwife?

_____

Will they be present for delivery?

○ Yes ○ No

Who is your birth provider?

_____

64. Do you intend to have a doula or birth coach present?

○ Yes ○ No

65. If yes, please explain:

_____

_____

_____

_____

66. Do you wish to have a natural labor and delivery?

○ Yes ○ No

67. If not, what concerns do you have?

_____

_____

_____

_____

Your Post Birth Plan

68. Do you plan on breastfeeding your child?

- ○ Yes
- ○ No

69. What do you intend to do for vaccines?

70. Is there anything else you'd like to tell us about your pregnancy or birth plan?

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

72. Are there any burning questions you want to be sure to ask today?

Patient Review of Systems

Below you will find 5 different sections with various conditions, symptoms or states of your system.

Please **CHECK** all boxes currently most associated with your health right **NOW,** or you have had in the **PAST**.

Your doctor will then use this in conjunction with the additional assessment testing to determine the type of care needed to serve you best.

73. Section 1

- ☐ High Energy
- ☐ Mentally Alert
- ☐ Few Symptoms
- ☐ Excellent Health
- ☐ Resistant to Infections
- ☐ Positive Mental Attidude
- ☐ Active
- ☐ Vibrant
- ☐ Not Applicable

74. Section 2

- ☐ Poor Attention
- ☐ Spaciness
- ☐ Impulsive
- ☐ Easily Distracted
- ☐ Constipation
- ☐ Low Pain Threshold
- ☐ Disorganized
- ☐ Difficulty Walking
- ☐ Poor Concentration

- ☐ Depressed
- ☐ Irritable
- ☐ Lacking Motivation
- ☐ Worry
- ☐ Low Energy
- ☐ Not Applicable

75. Section 3

- ☐ Cold Hands
- ☐ Poor Expression of Emotions
- ☐ Poor Immune System
- ☐ Cold Feet
- ☐ High Blood Pressure
- ☐ Accelerated Aging
- ☐ Tight Muscles
- ☐ Racing Mind
- ☐ Heart Palpitations
- ☐ Teeth Grinding
- ☐ Irritable Bowel
- ☐ Restless Sleep
- ☐ Anxious
- ☐ Not Applicable

76. Section 4

- ☐ Migraines
- ☐ Bed Wetting/Bladder Issues
- ☐ Sleepwalking
- ☐ Bipolar Disorder
- ☐ Eating Disorder
- ☐ Food Sensitivities
- ☐ Seizures
- ☐ Headaches
- ☐ Panic Attacks
- ☐ PMS
- ☐ Mood Swings
- ☐ Hot Flashes
- ☐ Not Applicable

77. Section 5

- ☐ Cancer
- ☐ ALS
- ☐ Rheumatoid Arthritis
- ☐ Epstein-Barr Syndrome
- ☐ Multiple Sclerosis
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Depression
- ☐ Autoimmune Disease
- ☐ Chronic Fatigue Syndrome
- ☐ Not Applicable

The TRUTH: The Disease Process *90-95% of disease is due to STRESS (not genetics) *Pre-birth brain controlled the development of EVERY SYSTEM *Post-birth brain controls and coordinates EVERY FUNCTION in your body *The longer the dysfunction, the more severe the disease (earliest correction is BEST) *The brain should be able to "fix" any issue IF it can communicate properly *STRESS affects the brain's ability to communicate properly *Poor brain function equals poor body function leading to symptoms and disease
By signing below, I am agreeing that I have read the information presented above.

_____
Signature

Stress Scale

Below is a list of stressors that adults can experience during their life, and will impact their health. Beside each stress, you will see a number listed. That is called a "Life Change Unit". Please write the value listed in "Life Change Units" for each of the stressors you have experienced in the past, or are experiencing currently.
The **total sum** of life change units will help the doctors and team to have a rough estimate on how greatly your stressors are affecting your life.

78.

Life Event - Life Change Unit	My Score

Death of a spouse - 100	
Divorce - 73	
Marital Separation - 65	
Imprisonment - 63	
Death of a close family member - 63	
Personal injury or illness - 53	
Marriage - 50	
Dismissal from work - 47	
Marital Reconciliation - 45	
Retirement - 45	
Change in health of family member - 44	
Pregnancy - 40	
Sexual Difficulties - 39	
Gain a new family member - 39	
Business Readjustment - 39	
Change in Financial State - 38	
Death of a close friend - 37	
Change to a different line of work - 36	
Change in frequency of arguments - 35	
Major Mortgage - 32	
Foreclosure of a mortgage or loan - 30	
Change in responsibilities at work - 29	
Child leaving home - 29	
Trouble with in-laws - 29	
Outstanding personal achievement - 28	
Spouse starts or stops work - 26	
Beginning or end of school - 26	
Change in living conditions - 25	
Revision of personal habits - 24	
Trouble with boss - 23	
Change in working hours or conditions - 20	
Change in residence - 20	
Change in schools - 20	
Change in recreation - 19	

Change in church activities - 19	
Change in social activities - 18	
Minor mortgage or loan - 17	
Change in sleeping habits - 16	
Change in number of family reunions - 15	
Change in eating habits - 15	
Vacation - 13	
Major Holiday - 12	
Minor violation of law - 11	

What is your total score?

_____

What does that score mean?

Score of 300+: At risk of illness

Score of 150-299: Risk of illness is moderate (reduced by 30% from the above risk)

Score of 150 or less: Only a slight risk of illness

ACKNOWLEDGEMENT & CONSENT

_____

Signature

79. Please answer below if you DO or DO NOT allow your image (photographs and/or videos) or likeness to be used in Media publications including, but not limited to: Social Media Posts, Videos, Email Blasts, Educational Brochures, Newsletters, Handouts, Magazines, General Publications, Website and/or Affiliates.

○ Yes, I DO consent ○ No, I DO NOT consent