Thank you for choosing Crossroads Family Chiropractic to assist in your pregnancy healthcare needs. Please fill out the following form as thoroughly as possible so that the doctor may better serve you and your developing baby. We look forward to working with you to build better health for your family.

PERSONAL INFORMATION

Patient Name _____ Female ☐ Male ☐

Date of Birth____/___/_____ Age_____ SS Number ____-___-_____

Home Address _____City_____ State___ Zip_____

Home Phone (____)____-_____ Cell (____)____-_____ Email _____

Occupation _____ Employer _____

Employer Address _____ Employer Phone (____)_____-_____

Spouse/Partner Name _____ Spouse/Partner Phone (___)____-_____

Who may we thank for referring you to the office? _____

RELEASE

I, the undersigned, authorize the Dr. and her staff to release any information deemed appropriate concerning my physical condition to any insurance company, claims adjuster, case nurse, claims reviewer, employer, health care provider or attorney in order to process any claim for reimbursement or charges incurred by me as a result of professional services rendered and hereby release him/her of any consequences thereof. I agree that a photo static copy of this agreement shall serve as the original.

X_____

Patient Signature Date

REASONS FOR SEEKING CHIROPRACTIC CARE
The initial goal of treatment is to address your current concerns. Please, briefly describe why you are seeking care for yourself today, and answer the questions that follow.

Complaint: _____ Date of Onset: _____

Can you relate this concern to anything? _____

If you are experiencing pain, is it? Sharp □ Dull Ache □ Throbbing □ Stabbing □ Numbness □ Pins and Needles □

Does the pain travel/radiate anywhere? No □ Yes □ - please describe on the lines provided below

_____

Since the problem started, it is? Getting worse □ About the Same □ Getting better □

What makes it feel 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? _____

Please list other doctors you have visited for this condition.

Name _____ Specialty _____ Date Visited ____/___/_____

Special Tests/X-Rays _____Diagnosis _____

Treatment _____Did it help? ____ How?_____

Have you ever had chiropractic care? No □ Yes □

HEALTH HISTORY
Have you had any surgery? (please include **ALL** surgery)

1.Type_____ Date:_____ 2.Type_____ Date:_____

3.Type_____ Date:_____ 4.Type_____ Date:_____

Accidents and/or injuries: auto, work related, or other (especially those related to your present problems).

1.Type_____Date:_____Hospitalized: No □ Yes □

2.Type_____Date:_____Hospitalized: No □ Yes □

Research is showing that many of the health challenges that occur later in life originated during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

Birth to 17 yrs. of age	Yes	No	Unsure	Comments
Did you have any serious childhood illnesses?	□	□	□	_____
Did you have any serious falls as a child?	□	□	□	_____
Did you play youth sports?	□	□	□	_____
Did you take/use any drugs (prescribed or not)?	□	□	□	_____
Was there prolonged use of medicine such as antibiotics/inhalers?	□	□	□	_____
Did you suffer any other traumas (physical or emotional)?	□	□	□	_____
Were you vaccinated?	□	□	□	_____
Were you ever diagnosed with scoliosis?	□	□	□	_____

PREGNANCY HISTORY

How many times have you been pregnant before? _____

Were there any problems during your past pregnancies? If yes, please explain

_____

_____

Were there any problems during past labor and deliveries? If yes, please explain

_____

_____

Third Trimester, presentation of baby (circle): □ Normal □ Breech □ Transverse □ Face/Brow

Type of birth (circle): □ Vaginal □ Planned Cesarean □ Suction/Vacuum/Forceps
□ Water Birth □ Emergency Cesarean □ Other Obstetrical Intervention

Did you receive an epidural for any or all of the deliveries? Yes □ No □

Current Pregnancy

What is the term of your pregnancy? _____Weeks

Check (√) which of the following you are experiencing and explain:

□ Abnormal Bleeding	□ Motor Vehicle Accident	□ High Blood Pressure	□ Diabetes
□ Anemia	□ Falls	□ Fainting	□ Swollen Ankles
□ Morning Sickness	□ Indigestion	□ Back Pain	□ Leg Pain
□ Neck Pain	□ Headaches	□ Hospitalizations	□ Other _____

Social History While Pregnant

1) Do exercise regularly? Yes □ No □ If yes, How many times per week? _____
2) Do you eat at a balanced/nutritious diet? Yes □ No □
3) Do you obtain sufficient rest (8 hrs)? Yes □ No □ How many hours per night? _____
4) Do you smoke? Yes □ No □
5) Do you drink caffeinated drinks? Yes □ No □ If yes, how many per day? _____

List Any Medications You Are Taking While pregnant (prescription or over the counter):

_____

_____

List Any Vitamins/Minerals/Herbs/Homeopathics You Are Taking While Pregnant: _____

_____

_____

Are you taking any childbirth education classes? Yes □ No □ If yes, please describe:

_____

_____

Please describe the goal of your labor and delivery for this pregnancy (examples: hospital, home, natural, medicated, vaginal, the use of water, etc.)_____

_____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation:

X _____

Signature of Patient **Date**