Patient File # _____

Date: ____/_____/_____

Postpartum Information Form

Thank you for choosing Crossroads Family Chiropractic to assist in your postpartum healthcare needs. The first few months after delivery are vital to your health and how you recover lays the groundwork for your body's future. We are honored to help you in your journey.

PERSONAL INFORMATION

Patient Name _____

Date of Birth____/___/_____ Age_____

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? _____

Do we have your authorization to thank them for referring you? Yes No

Would you like to receive our newsletter? (Whole foods recipes, health devotionals, office updates, etc) Yes No

Would you like to receive text reminders for upcoming appointments? Yes No

*If so, please list your provider:*_____

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

Patient File # _____

Date: ____/_____/_____

Postpartum Information Form

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?_____

Do we have you authorize our office to contact your doctors to discuss previous medical care? No □ Yes □

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 shows 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 present 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)?	€	€	€	_____
Did you suffer any other traumas (physical or emotional)?	€	€	€	_____
Did/Do you have any autoimmune diseases?	□	□	□	_____
Did/Do you have any food sensitivities or food allergies?	□	□	□	_____
Did/Do you have any thyroid issues? (Hyper/Hypo/Grave's/Hashimoto's)	□	□	□	_____

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Postpartum Information Form

PREGNANCY HISTORY

How many times have you been pregnant before? _____

Were there any problems during **PAST** pregnancies (during gestation, labor, delivery)? If yes, please explain

_____

_____

Were there any problems during **THIS** labor and delivery? If yes, please explain

_____

_____

Please describe your most recent birth:

Baby presentation: € 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? Yes € No €

Did you experience any of the following during your pregnancy?

□ Pain going from sitting to standing
□ Pain when moving in bed
□ Inability to bear weight on a leg
□ Leg giving way
□ Popping, clicking, shifting in any joint?
□ Pain with lifting
□ Pain when walking or standing
□ Tailbone pain
□ Urinary incontinence

Current

When did you have your child? _____ weeks / months ago

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

Pain Symptoms

€ Abnormal Bleeding
€ Back Pain
€ Leg Pain
€ Neck Pain
€ Headaches

Have you been diagnosed with
Diastasis Recti □ Yes □ No
If yes, how big? _____

Pelvic Health Symptoms

□ Gradually increasing discomfort in vagina, pelvis, abdomen or low back
□ Pressure in vagina at the end of the day
□ Increasing difficulty with bowel movements
□ Pain or uncomfortable pressure during intercourse
□ Decrease in sexual pleasure
□ Bladder leakage
□ Fecal Leakage (Gas/stool)
□ Trouble starting or hesitant stream
□ Urgency and Frequency (going more than 7 times a day)
□ Bulge of tissue seen or felt at vaginal opening
□ Difficulty in retaining tampon

Please circle the response that comes closest to how you have been feeling IN THE PAST 7 DAYS.
Please answer all questions.

Here is an EXAMPLE already completed.
I have felt happy:

0 Yes, all the time
1 Yes, most of the time
2 No, not very often
3 No, not at all

This would mean: "I have felt happy most of the time" during the past week. Please complete the other questions in the same way.

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Postpartum Information Form

Please answer all of the questions below:
Circle one answer in each question.

1. I have been able to laugh and see the funny side of things.
   - 0 As much as I always could
   - 1 Not quite so much now
   - 2 Definitely not so much now
   - 3 Not at all

2. I have looked forward with enjoyment to things
   - 0 As much as I ever did
   - 1 Rather less than I used to
   - 2 Definitely less than I used to
   - 3 Hardly at all

3. I have blamed myself unnecessarily when things went wrong
   - 3 Yes, most of the time
   - 2 Yes, some of the time
   - 1 Not very often
   - 0 No, never

4. I have been anxious or worried for no good reason
   - 0 No, not at all
   - 1 Hardly ever
   - 2 Yes, sometimes
   - 3 Yes, very often

5. I have felt scared or panicky for no good reason
   - 3 Yes, quite a lot
   - 2 Yes, sometimes
   - 1 No, not much
   - 0 No, not at all

6. Things have been getting on top of me
   - 3 Yes, most of the time I haven't been able to cope at all
   - 2 Yes, sometimes I haven't been coping as well as usual
   - 1 No, most of the time I have coped quite well
   - 0 No, I have been coping as well as ever

7. I have been so unhappy that I have had difficulty sleeping
   - 3 Yes, most of the time
   - 2 Yes, sometimes
   - 1 Not very often
   - 0 No, not at all

8. I have felt sad or miserable
   - 3 Yes, most of the time
   - 2 Yes, quite open
   - 1 Not very often
   - 0 No, not at all

9. I have been so unhappy that I have been crying
   - 3 Yes, most of the time
   - 2 Yes, quite often
   - 1 Only occasionally
   - 0 No, never

10. The thought of harming myself has occurred to me
    - 3 Yes, quite often
    - 2 Sometimes
    - 1 Hardly ever
    - 0 Never

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**