Pregnancy Application for Care

For expecting moms-to-be

RESTORE FAMILY CHIROPRACTIC

Is this appointment alone or with a family member?

◯ Family Member (same day) ◯ Family Member (different day) ◯ Alone

Confidential Personal Information

Name: _____

Date Of Birth: _____ Cell: _____

Address _____ Other Phone _____

City/State/zip _____ Email _____

Primary Care Physician _____ Preferred Contact Method: ◯ Text me ◯ Call me

Currently seeing any other health care providers? _____

Do any other family members have an appointment?

☐ Yes, in the same week as mine ☐ Yes, I was referred by them ☐ No, but I'd like to schedule them ☐ No, but let's talk about that later

How did you hear about us?

◯ Referral from Current Patient ◯ Google search ◯ Facebook/Instagram ◯ I saw you at an event

◯ Midwife / Primary Care Provider ◯ I saw your sign ◯ Other: _____

Have you had previous chiropractic care? ◯ yes ◯ No

Where?_____ When? _____

Pregnancy Profile

How many weeks in your pregnancy are you? _____ What is your due date? _____

Where do you intend to give birth? ◯ Home ◯ Birthing Center ◯ Hospital ◯ Other

Please list any medications or supplements you have taken during pregnancy:

_____

_____

Have you experienced any physical trauma during this pregnancy? ◯ yes ◯ No _____

Have there been any stressful events during this pregnancy? ◯ yes ◯ No _____

Previous Pregnancies? ◯ yes ◯ No If yes, how many? _____ Ages of children _____

How many vaginal? _____ How many Caesarean? _____ Any known miscarriages? ◯ yes ◯ No

Any complications from previous deliveries? ◯ yes ◯ No Did you experience back/hip pain? ◯ yes ◯ No

Did your provider rupture your membranes? ◯ yes ◯ No Did you receive an epidural? ◯ yes ◯ No

Were any operative devices used? ◯ No ◯ Forceps ◯ Vacuum

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Symptoms

What is the purpose of today's appointment?

◯ Wellness Checkup ◯ I am experiencing symptoms ◯ I am pursuing natural childbirth options

If you are experiencing symptoms, what are they?

_____

How long have you felt them? _____ How often do you feel them? _____

What makes them better? _____ What makes them worse? _____

On a scale of 1 to 10, how does it feel at its worst? _____

How would you describe the pain/discomfort? ◯ Dull ◯ Achy ◯ Throbbing ◯ Stabbing ◯ Tight ◯ Burning

Have you experienced any of the following symptoms during this pregnancy or a previous pregnancy?

Past	Current		Past	Current	
◯	◯	Headaches	◯	◯	Numbness in hands/fingers
◯	◯	Facial Paralysis	◯	◯	Low/Mid back pain
◯	◯	Chronic Fatigue	◯	◯	Breech or Sidelying Presentation
◯	◯	Nausea/Morning Sickness	◯	◯	Round Ligament pain/pulling
◯	◯	Heartburn	◯	◯	Pubic Bone Pain
◯	◯	Preeclampsia	◯	◯	Pins/Needles on front/side of leg
◯	◯	Constipation	◯	◯	Leg Cramps
◯	◯	Hemorrhoids	◯	◯	Swelling of Ankles, Legs, or Feet

Any history of falls or physical traumas?

_____

_____

Any car accidents?

_____

_____

Any Surgeries or hospitalizations?

_____

How many hours/day on a computer? _____

How many hours/day of screentime? _____

Toxicity

Please rate your stress level in the following categories:

	None	Some	Moderate	High	Severe
Home	◯	◯	◯	◯	◯
Work	◯	◯	◯	◯	◯
Money	◯	◯	◯	◯	◯
Health	◯	◯	◯	◯	◯
Family	◯	◯	◯	◯	◯

Please rate your consumption of each:

	None	Some	Moderate	A lot
Water	◯	◯	◯	◯
Alcohol	◯	◯	◯	◯
Tobacco	◯	◯	◯	◯