B ! R T H F ! T

FITNESS, NUTRITION, CHIROPRACTIC & MINDSET

maxliving

NEW LIFE CHIROPRACTIC

Pregnant Patient Intake

Today's Date _____

Name_____
Age ____ Date of Birth _____Parent's name (if you are under 18)_____
Home Address_____ City _____ State_____ Zip _____
Cell phone (____) _____ Business Phone (____) _____
E-mail address (please print clearly) _____
Occupation/Employer_____

Emergency contact _____

Marital Status S M D W Live In Spouse/Partner
(Please provide contact if different from above)
_____

Have you had any previous or concurrent treatments in this office: Y / N
If yes, what for and are you under continued care? If yes, please skip the next question.
_____
_____

How did you find us? _____

Weeks _____ Estimated Due Date: _____
# of Pregnancies _____ # of Vaginal Births _____ # of Cesarean Births _____
Names and Ages of Children _____

Brief Previous Birth History

_____
_____

Birth Team
Midwife: _____OB/GYN: _____
Doula:_____ Other: _____
Where will you be birthing your baby?
Hospital_____ Home_____ Birthing Center_____ Other_____

Have you taken, or do you plan to take, any childbirth education classes?
_____

What is your reason for scheduling an appointment and showing up today?
(The more details the better.)

☐ Chiropractic Care
☐ BIRTHFIT Basics Consultation
☐ Diastasis Rectus Abdominis
☐ Urinary Incontinence
☐ Pelvic Floor Dysfunction
☐ Lower Back Pain or Discomfort
☐ Groin and/or Pubic Area Pain or Discomfort
☐ Breech, Transverse, or Posterior Baby
☐ Other: _____

What concerns do you have at this moment? (Please circle)

Y N WORK
Y N SLEEP
Y N SCHOOL
Y N MONEY
Y N PROFESSIONAL ATHLETIC CAREER
Y N PREGNANCY PROCESS
Y N HEALTH OF UNBORN CHILD
Y N CURRENT RELATIONSHIP
Y N CURRENT HEALTHCARE TEAM
Y N OPINIONS OF YOUR FAMILY/FRIENDS
OTHER_____

Who is on your healthcare team?

_____
_____
_____
_____

The primary system in the body which coordinates health is the CENTRAL NERVOUS SYSTEM. The vertebrae (bones of the spinal column) surround and protect the delicate NERVOUS SYSTEM. Chiropractors are specialists trained in "early detection" of injury to the SPINE & NERVOUS SYSTEM.

Have you ever received Chiropractic care? Y N
Name of D.C._____
How long under care? _____days _____weeks ____ months ____ years_____
Date of last visit: _____Why did you stop, if you did ?_____

Do you regularly consult any of the following providers? If yes, please list their names.

Medical Doctor _____
Acupuncturist _____
Physical Therapist _____
Naturopath _____
Psychotherapist _____
Dentist _____

Who is your primary care medical doctor and/or functional medicine doctor?
_____

The minor and often ignored repetitive physical traumas that we have endured are often too numerous to list. Please list the major traumas that you remember from your childhood up to the present.
_____
_____
_____
_____

Have you had any accidents or injuries in your life related to any of the following? If yes, state type of injury and date: _____
_____

Have you ever hurt/injured your spine, head, neck, ribs, chest, upper or lower back, pelvis or hips? If yes, state type of injury and date:
_____
_____

Have you ever hurt, broken, fractured or sprained any bones or joints? If yes, list body parts injured and dates: _____
_____

Have you ever been hospitalized? If yes, state reason and dates:
_____
_____

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if you have experienced any of the emotional stresses below:

Childhood Trauma Y N
Loss of Loved One Y N
Abuse Y N
Divorce/Separation Y N
Financial Y N
Work/School Y N
Illness Y N
Lifestyle Change Y N

Do you move regularly?
Functional movement training can be the best supplement to a busy lifestyle. Exercise enhances overall health for everyone involved, mom and baby.

How many days a week do you train?_____
Do you have any rest/recovery days?_____
What type of training do you do? _____
Do you incorporate any strength training into your workouts? _____

Are there any movements that you avoid due to an injury or belief?
_____
_____

Do you incorporate any recovery style treatments? (i.e. massage, rolfing, floating, sauna, other body work)
_____
_____

Describe your typical week of training.

Does chemical stress sneak into your daily life?
This can occur when a substance, that is toxic to the body, is breathed, injected, taken by mouth, or placed on the skin (e.g.: food allergies, drug reactions, exposure to chemicals in the air, etc.)

Do you drink tap, filtered, or bottled water majority of the time? _____

Have you ever had any dental (amalgam) fillings? _____
Were you vaccinated? Y N If yes, did you have a reaction? Y N

Have you been exposed to any of the following on a regular basis, (past or present)?
☐ Toxic Chemicals
☐ Second Hand Smoke
☐ Radiation
☐ Chemotherapy
☐ Drug Therapy
☐ Other: _____

Do you have **allergies or sensitivities to any foods** that you are aware of? Y N If yes, please list:_____

Do you presently consume any of the following?
☐ Coffee/Caffeine
☐ Alcohol

☐ Tobacco
☐ Over The Counter Drugs
☐ Supplements:
Please list all **supplements** (prescribed and over the counter):
_____
☐ Prescribed Drugs:
Please list all **medications** (prescribed and over the counter):
_____

Note: It is imperative that you list all medications as they may have an influence on your care.

Tuning Into You.
(A= Great, B= Good, C= Needs Improvement, D= No Where to Go But Up)

How do you grade your physical health?
☐ A
☐ B
☐ C
☐ D

How do you grade your emotional health?
☐ A
☐ B
☐ C
☐ D

How do you rate your overall “quality of life”?
☐ A
☐ B
☐ C
☐ D

The information I have provided on this form is true and accurate to the best of my knowledge. I give Catherine De Lipski Smith, D.C. permission to consult, program, and advise according to their expertise and experience.

Signature_____Today’s Date_____
Signature of Parent (for minor):_____ Today’s Date_____