632 Maine Street
Quincy, IL 62301
217-779-6504

Pregnancy Health History Form

Name:____ Date:______________________

Age:__________ Date of Birth:____________________

Email address:____

Home address:____

Phone: (H)____________________ (W)_____________________ (C)____________________

Occupation:______________________ Who may we thank for referring you?________________

Family doctor's name and address:____

WHY THIS FORM IS IMPORTANT: Our focus is on assisting you to function optimally, become healthier and improve your ability to adapt to everyday stresses. Completion of this form provides us with an improved understanding of your physical, chemical and emotional stresses that can gradually overwhelm the body and contribute to your health concerns. Please complete this form as thoroughly as possible and the doctor will review it with you. Information collected and discussed on this form is strictly confidential and can only be shared with your consent.

1. About Your Pregnancy

Is this your first pregnancy? **YES** **NO** If no, how many times have you been pregnant? ________

Have you had any complications with previous pregnancies? **YES** **NO** If yes, please explain.

____

If you have had miscarriage(s), how far along in your pregnancy did it occur? ________________

____

What is the estimated date of delivery? ____

Who is your primary care giver for delivery? ____

How do you feel about this pregnancy? ____

Do you have any special arrangements for the birth? (Planned C-section, water delivery, other)
YES **NO** If yes, please explain. ____

Have you had any testing? (Genetic, blood, ultrasound, amniocentesis, chorionic villi sampling, other) **YES** **NO** If yes, please explain and dates. ____

____

Are you planning on breastfeeding post-delivery? **YES** **NO**

Was your blood pressure prior to pregnancy within normal range, low or high? ________________

What was your most recent blood pressure and when was it last checked? ____________________

Have you made healthy eating choices since learning of your pregnancy? **YES** **NO**

Have you smoked prior to or along with this pregnancy? **YES** **NO** **QUIT**

Have you had alcohol during this pregnancy? **YES** **NO**

Have you noticed any of the following:

- Swelling in the arms or legs? **YES** **NO**
- Low back pain **YES** **NO** How often? ____
- Upper back pain **YES** **NO** How often? ______________________________________
- Neck pain? **YES** **NO** How often? ____
- Rib or chest pain? **YES** **NO** How often? ____________________________________
- Foot pain? **YES** **NO** How often? ____
- Digestive complaints? **YES** **NO** How often? _________________________________
- Nausea or vomiting? **YES** **NO** How often? __________________________________
- Arm or hand numbness/tingling **YES** **NO** How often? __________________________
- Dizziness or lightheadedness? **YES** **NO** How often? ___________________________
- Headaches? **YES** **NO** How often? ____
- Pain radiating down the leg(s)? **YES** **NO** How often? _________________________
- Heart palpitations? **YES** **NO** How often? ___________________________________

2. Current Health Concern (if there are no current concerns and this assessment is to ensure optimum health, function and wellness, check this box) ☐

Health concern:____

____

If pain is involved, rank it on this scale (0=no pain, 10=extreme pain): 0 1 2 3 4 5 6 7 8 9 10

Circle the quality: sharp dull ache burning tingling throbbing spasm other:________________

When did you first notice it?____

Describe what happened:____

How often does it occur?________________________________ What relieves it?______________________

What aggravates it?_________________________________ Does it radiate to other parts of your body?

________________________________ Other professionals seen for this:_____________________________

Other health concerns: Please note all other health concerns in the past (P) or current (C).

P C		P C		P C	
☐ ☐	ADD	☐ ☐	Epilepsy	☐ ☐	Migraines
☐ ☐	Allergies	☐ ☐	Fatigue	☐ ☐	Miscarriage
☐ ☐	Asthma	☐ ☐	Fertility issues	☐ ☐	Multiple sclerosis
☐ ☐	Appendicitis	☐ ☐	Frequent colds/sickness	☐ ☐	Numbness/tingling
☐ ☐	Autoimmunity	☐ ☐	Headaches	☐ ☐	Osteoarthritis
☐ ☐	Bleeding disorders	☐ ☐	Heartburn	☐ ☐	Osteoporosis
☐ ☐	Bloating	☐ ☐	Hepatitis	☐ ☐	Parkinson's disease
☐ ☐	Bronchitis	☐ ☐	Hernia	☐ ☐	Pinched nerve
☐ ☐	Cancer:________________	☐ ☐	Herniated disc	☐ ☐	Pneumonia
☐ ☐	Cardiovascular disease	☐ ☐	High cholesterol	☐ ☐	Prostate problems
☐ ☐	Cataracts	☐ ☐	Hypertension	☐ ☐	Psoriasis
☐ ☐	Constipation	☐ ☐	Hypoglycemia	☐ ☐	Rheumatoid arthritis
☐ ☐	Diabetes	☐ ☐	Indigestion	☐ ☐	Stroke
☐ ☐	Diarrhea	☐ ☐	Kidney disease	☐ ☐	Thyroid issues
☐ ☐	Difficulty concentrating	☐ ☐	Lightheadedness	☐ ☐	Tonsillitis
☐ ☐	Digestive issues	☐ ☐	Liver disease	☐ ☐	Ulcerative colitis
☐ ☐	Dizziness	☐ ☐	Loss of balance	☐ ☐	Ulcers
☐ ☐	Emphysema	☐ ☐	Menstrual pain/dysfunction	☐ ☐	Urinary tract infection
				☐ ☐	Other:______________

3. Family Health History: Please note if your spouse (SP), son (S), daughter (D), mother (M) or father (F) have or have had any of the following conditions.

Arthritis_____________	Diabetes_________________	Menstrual disorder__________
Asthma______________	Digestive issues__________	Migraines__________________
ADD/ADHD__________	Disc problems____________	Neck pain__________________
Allergies_____________	Ear infections_____________	Scoliosis____________________
Back troubles________	Fibromyalgia______________	Shoulder pain_______________
Bed wetting__________	Headaches________________	Sinus issues_________________
Cancer______________	High blood pressure_______	Stroke______________________
Carpal tunnel________	Hip pain__________________	TMJ disorder________________

4. Physical Stresses:

Any significant injuries, falls or traumas during infancy or childhood? **YES NO UNSURE**
(if yes please explain)____

Any significant injuries, falls or traumas during adulthood? **YES NO UNSURE**
(if yes please explain)____

Any hospital visits? **YES NO** Have you had any surgeries, fractures, accidents? **YES NO**
(if yes explain and dates)____

Any repetitive postures or movements on a daily basis (sitting, factory work, driving)? **YES NO**
(if yes please explain)____

Any hobbies that are physically strenuous or have repetitive movements? **YES NO**
(if yes please explain)____

Any vehicle accidents? **YES NO** Describe and dates_____________________________________

What is your usual exercise routine?____
Give yourself a score from 0-10 on the overall physical stresses in your life (0=no physical stress, 10=maximal physical stress)____

5. Chemical Stresses:

Do you take prescription or over-the-counter medications? **YES NO** Name of medication and reason____
____

Do you take supplements? **YES NO** Supplement and reason______________________________
____

Do you smoke? **YES NO** Packs per day____

Do you drink alcohol? **YES NO** Drinks per day____

Do you eat processed food, junk food, fast food, sweets, etc. regularly? **YES NO OCASSIONALLY**

Do you drink soda, diet soda, energy drinks, or sports drinks regularly? **YES NO OCASSIONALLY**

Are you exposed to pollutants, strong smells, or chemicals regularly? **YES NO OCASSIONALLY**

Do you use natural products in your home (skin care, hair care, cleaning supplies, etc.)? **YES NO**

Give yourself a score from 0-10 on the overall chemical stresses in your life (0=no chemical stress, 10=maximal chemical stress)____

6. Mental/Emotional Stresses:

Rank the following areas of your life from 0-10 (0=no mental/emotional stress, 10=maximal mental/emotional stress):

Relationships______________ Work/career______________ Finances______________ Hobbies___________
Time management______________ Quality of sleep______________ Health______________

Do you practice some form of prayer, breath work, meditation or other activity to reduce your stress? **YES** **NO** Explain____

Give yourself a score from 0-10 on the overall mental/emotional stresses in your life (0=no mental/emotional stress, 10=maximal mental/emotional stress)_____________________________________

7. Reason you are here:

People seek chiropractic care for a number of reasons and have certain expectations. Please indicate your reason for choosing chiropractic.

☐ Wellness ☐ Improved quality of life ☐ Prevention ☐ Improved function
☐
Improved performance ☐ Drug-free healthcare ☐ Improved immune system ☐
Pain reduction ☐ Symptom reduction ☐ Other:____

Consent for examination: Please read carefully

In order for my health professional as indicated below to make a determination on the suitability of my case for care, I acknowledge and understand that I must complete a thorough evaluation. I do hereby request and consent to the performance of such an evaluation by the person(s) named below, or any party authorized to do so by that person.

I have had the opportunity to discuss with the Doctor of Chiropractic indicated below, or with any party authorized to do so by that Chiropractor, about the nature and purpose of the examination process. I understand that there may be remotely associated risks with examinations, as there are with any and all healthcare treatments. In healthcare, the matter of whether any treatment is appropriate or not is determined by looking at the level of risk and comparing this with the level of expected benefit. I understand that I may ask the doctor to stop the examination at any time. I also understand that by signing this form, the Chiropractor continues to be obligated for best practices delivered in my interests.

Name:____ Date:________________________________

Signature:____ Witness:_____________________________

Doctor of Chiropractic:_______________________________