

THE CHILDREN'S FAMILY CHIROPRACTIC CENTER
CONFIDENTIAL CLIENT INFORMATION
MATERNAL HISTORY FORM

Name: _____ Date: _____

Address: _____
Residence/Mailing City State Zip Code

Home Phone #: _____ Work Phone #: _____ Male

Female

Email Address: _____ Date of Birth: _____

Marital Status: S M W D Name of spouse: _____ Occupation: _____

No. of Children: _____ Names & Ages: _____

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

What are your objectives in consulting this office? Wellness Preventative Care Other: _____

If you'd like us to check if you have insurance coverage, please let us know.

WHY THIS FORM IS IMPORTANT

As a full spectrum Chiropractic office, we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity of improved health potential and wellness services. On a daily basis we experience, physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

YOUR HEALTH PROFILE

If you have no symptoms or complaints, and are here for wellness services, please check here ____ "Wish to have Chiropractic Wellness Services". Otherwise, please briefly describe your health challenge including the effect it has had on your life.

Name of MD or Midwife: _____

Date of Last Menstrual Period: _____ Expected Due Date (EDD): _____

Chief Complaint: _____

If you are experiencing pain, is it...

Sharp Dull Comes & Goes Travels Constant

Since the problem started, it is...

About the same Getting Better Getting Worse

Yes, it interferes with:

Work Sleep Walking Sitting Hobbies Leisure

What makes it worse?

Other doctors I've seen for this problem:

Chiropractor _____

Medical Doctor _____

Other _____

Menstrual History:

What is a normal menstrual cycle for you? PMS, PCB, IMB, vaginal itching, hygiene habits (douching, bowel care, powders) _____

Previous Birth Control Methods: _____

Previous Pregnancies/Children:

of previous pregnancies: _____ # of Children: _____ Ages: _____

Dates of Delivery: _____

Locations: _____

Duration of gestation: _____

Type of Delivery: _____

Duration of Labor: _____

Type of anesthesia if any: _____

Maternal complications: _____

Newborn gender, weight, complications, APGAR: _____

Have you had any of the following:

- | | | |
|--|---|---|
| <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Tubal Pregnancy | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Abortion | <input type="checkbox"/> Hemorrhaging | <input type="checkbox"/> Use of Birth Control Pills _____ |
| <input type="checkbox"/> Stillbirth | <input type="checkbox"/> Pre-eclampsia | <input type="checkbox"/> I.U.D. Use |
| <input type="checkbox"/> C-section | <input type="checkbox"/> Diabetes | |
| <input type="checkbox"/> Breech presentation | <input type="checkbox"/> Thyroid Disease | |
| <input type="checkbox"/> Multiple Births | <input type="checkbox"/> Abnormal PAP Smear | |

Current Pregnancy:

Are you taking any prescription drugs? _____

Are you taking any vitamins or herbs? _____

Are you currently or have you during pregnancy experienced any of the following?

- | | | |
|---|--|--|
| <input type="checkbox"/> Spotting or bleeding | <input type="checkbox"/> Severe Morning Sickness | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Neck pain | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Bladder Infection | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Midback or Rib Pain |
| <input type="checkbox"/> Heart Burn | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Numb Hands |
| <input type="checkbox"/> Yeast Infection | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Hip Pain |

Have you had any laboratory testing? Yes No

What were the results? _____

HEALTH HISTORY

What was your birth like? _____

How long was the entire labor? _____ How long did your mom push? _____

Was there any pulling on the head? Y N Were you induced? Y N

Epidural? Y N C-section? Y N

Forceps or vacuum extraction? Y N

Please check all symptoms you have ever had:

- | | | |
|---|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Neck pain |
| <input type="checkbox"/> Pins & needles in legs | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Mood Swings |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Pins & needles in arms | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Menstrual Pain | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Cold Hands | <input type="checkbox"/> Neck stiffness |
| <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> Upset Stomach | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Menstrual Irregularity | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Cold Feet | |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Heartburn | |

Have you ever been hospitalized?

Have you ever had surgery of any kind? _____

Have you taken any medication?

Do you have any allergies?

Have you ever been in any accidents?

Social History:

Do you or have you ever:

Smoked _____

Abused Drugs, prescription or illegal _____

Been a victim of physical abuse _____

How often do you exercise and what kind of exercise do you do (type and frequency):

Before pregnancy:

After pregnancy:

Work History:

Job description and exposure to toxins or hazardous conditions: _____

Stress History (Job, Home, Family, Other):

Have you ever been to a chiropractor before? Yes No

How often? _____ Doctor's name? _____

Have you ever:

Bought bottled water: Yes No

Belonged to a health club: Yes No

Consumed vitamins or supplements: Yes No

Have you ever been to a doctor who put you on a health development plan?

Yes No I don't know

If Yes, what was his/her name? _____

How long were you on it? _____

What did it consist of? _____

What were the results? _____

Where they permanent? _____

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.

Signature

Date