Personal and Family Health History

Pregnancy Intake form

Name ____
Date _________________
Address ____
City ____________________ State ____ Zip ________
Phone: (H) _______________ (W) ________________
E-mail ____
Date of Birth _______________ (Age ______)

Referred By ___________________________________
Social Security # _______________________________
Occupation ____________________________________
Employer _____________________________________
Marital Status S M D W
Spouse's Name ________________________________
Spouse's Occupation ___________________________

Current health Condition

Present Complaint (be brief) Reason For Your Visit Today

Previous Chiropractic Care? Yes No

How many weeks pregnant are you? ____

Name of Provider or facility? ____

Is this your first child, if not how many?____

Any concern with position of baby?____

Are you having any discomfort?_______________________________________

Pains are: ☐ Sharp ☐ Dull ☐ Constant ☐ Intermittent

Is this interfering with? ______ Sleep? ______ Routine? ______ Other? _______

Movements or activities that make it worse?____

Movements or activities that make it better?____

Any home remedies? ____

Other Doctors or providers seen during your pregnancy?____

Other symptoms:

- ☐ Headaches
- ☐ Neck Pain
- ☐ Sleeping Problems
- ☐ Back Pain
- ☐ Nervousness
- ☐ Tension
- ☐ Irritability
- ☐ Chest Pains
- ☐ Dizziness
- ☐ Face Flushed
- ☐ Neck Stiff
- ☐ Pins & Needles in Legs
- ☐ Pins & Needles in Arms
- ☐ Numbness in Fingers
- ☐ Numbness in Toes
- ☐ Shortness of Breath
- ☐ Fatigue
- ☐ Depression
- ☐ Light Bothers Eyes
- ☐ Loss of Memory
- ☐ Ears Ring
- ☐ Fever
- ☐ Fainting
- ☐ Cold Sweats
- ☐ Loss of Smell
- ☐ Loss of Taste
- ☐ Diarrhea
- ☐ Feet Cold
- ☐ Hands Cold
- ☐ Stomach Upset
- ☐ Constipation
- ☐ Loss of Balance
- ☐ Buzzing in Ear

Have you been under drug and medical care? ____

What medications are you taking? ____

How Long? _________________ Have you had surgery? ________________ What? ________ When?__________

What side effects have you experienced from the drugs and surgery? ______________________________________

____ Signature

____________________ Date