

# PREGNANCY HEALTH HISTORY



Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Single  Married  Divorced  Widowed # of Children & Ages \_\_\_\_\_  
SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ E-mail \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation (describe) \_\_\_\_\_  
Spouse's Name \_\_\_\_\_ Spouse's Occupation \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_  Phone Book  Website  Sign  Other \_\_\_\_\_

**Prenatal History:** (circle, highlight or write where applicable)

- 1) Is this your first pregnancy? Yes No How many other births have you had? \_\_\_\_\_
- 2) How many weeks pregnant are you? \_\_\_\_\_ wks What is your estimated due date? \_\_\_\_\_
- 3) If you are in your 3<sup>rd</sup> trimester, what position is your baby in? Vertex (head down) Breech (see below)
- 4) Were there any challenges trying to conceive for this pregnancy? Yes No \_\_\_\_\_
- 5) Where do you plan on delivering? Home Birthing Center Hospital Other \_\_\_\_\_
- 6) Who is your birth care provider? Lay Midwife Nurse Midwife OBG Name \_\_\_\_\_
- 7) Who will you have with you at birth for support? \_\_\_\_\_
- 8) Have you put together a birth plan? Yes No
- 9) Have you experienced any traumas (accidents, falls) during this pregnancy? Yes No  
Please describe: \_\_\_\_\_
- 10) Have you had any evaluation procedures (ultrasound, amniocentesis, chorionic villus sampling)? Yes No  
Dates / frequency & reasons: \_\_\_\_\_  
\_\_\_\_\_
- 11) Have there been any stressful events in your life during this pregnancy? Yes No  
Please describe: \_\_\_\_\_
- 12) What are your most significant concerns associated with this birth? \_\_\_\_\_
- 13) Are you taking any prenatal supplements? Yes No (multi, fish oil, vit D) \_\_\_\_\_
- 14) Any medications during this pregnancy? Yes No \_\_\_\_\_

**Present State of Health (presenting symptoms):** Most pregnant women visit our office to give themselves and their baby the best opportunity to have a natural vaginal birth. However, some women also experience symptoms during their pregnancy. If you have a specific concern, please complete the following section. If you are here for a wellness visit, skip to the next section. (circle, highlight or write where applicable)

**If this visit is concerning a breech presentation, please complete the following:**

- a. What position is your baby in now? Transverse Complete Footling Frank Kneeling Other \_\_\_\_\_
- b. Was it confirmed by ultrasound? Yes No When was the last test to confirm the baby's position? \_\_\_\_\_
- c. At what gestational week did you first learn your baby was breech? \_\_\_\_\_ Wks
- d. Have you tried any procedures or maneuvers yet? Yes No Explain: \_\_\_\_\_
- e. Are you familiar with the chiropractic Webster Technique? Yes No

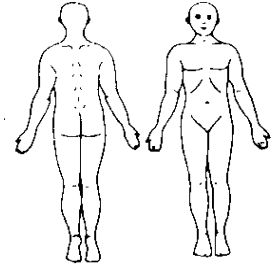
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**1<sup>st</sup> Concern** \_\_\_\_\_

Been a problem for: (please specify #) \_\_\_\_\_Day(s) \_\_\_\_\_Week(s) \_\_\_\_\_Month(s) \_\_\_\_\_Year(s)

- a. Quality of symptom is: Sharp Dull Numb Tingling Burning Stiff Other\_\_\_\_\_
- b. Condition came on: Sudden Gradual How:\_\_\_\_\_
- c. It is: Constant / Frequent (*daily*) / Intermittent (*several/wk*) / Occasional (*1/wk or less*)
- d. Feels worse in: AM Noon PM In Bed It Varies It's getting: Better Worse No Change
- e. Rate on a scale of 1-10 (*10 = worst*) at its worst:\_\_\_\_\_
- f. What makes it better?\_\_\_\_\_
- g. What makes it worse?\_\_\_\_\_
- h. Have you seen anyone for this? Yes No Who?\_\_\_\_\_
- i. How does it interfere with your life (sleep, work, play, driving, lifting, etc.)\_\_\_\_\_

**Mark areas below**



**Other Concerns** (*Please briefly describe*) \_\_\_\_\_

**Are ANY of the above complaints related to an auto or work injury?** Yes No\_\_\_\_\_

**Wellness Profile:** Chiropractic care affects more than just muscles, joints and how we feel. Chiropractic helps our bodies function at a higher level which increases our overall health and wellness. Please share with us what health goals you hope to achieve. (*Circle as many goals as you wish*)

- |                           |                       |                           |
|---------------------------|-----------------------|---------------------------|
| More Energy               | Better Sleep          | Freedom from Pain         |
| Easier Breathing          | Improved Posture      | Improved Nutrition & Diet |
| Improved Coordination     | Eliminate Medications | Improved Overall Health   |
| Better Sports Performance | Stress Reduction      | Better Concentration      |
| Stronger Immune System    | Other_____            |                           |

**Spinal Health:** (*circle, highlight or write where applicable*)

- 1) Have you ever visited a doctor of chiropractic before? Yes No Who?\_\_\_\_\_
- When was your last visit?\_\_\_\_\_ Reason for ending care?\_\_\_\_\_
- 2) Have you ever had spinal x-rays taken? Yes No When?\_\_\_\_\_ Were you standing? Yes No
- 3) Circle/explain if you have: Scoliosis Spinal Arthritis Inherited Spinal Problem\_\_\_\_\_
- 4) Spinal misalignments cause decay and degeneration which results in grinding or cracking.  
Do you ever hear noises when you move your head or neck? Yes No
- 5) Spinal misalignments can make you feel the need to twist, stretch or crack your neck or spine.  
Do you ever feel the need to twist, stretch or crack your neck or spine? Yes No
- 6) Poor posture leads to poor health and often indicates spinal problems. Please rate your posture.  
Poor - 1 2 3 4 5 6 7 8 9 10 - Excellent
- 7) Stress can cause or accelerate spinal damage. Rate your stress level over the last 90 days.  
Low - 1 2 3 4 5 6 7 8 9 10 - High
- 8) Have you ever had spinal surgery? Yes No If yes, when & where? \_\_\_\_\_

**Injuries/Surgeries:** (*Date & Description*)

Auto Accidents: N/A / \_\_\_\_\_

Recreational Accidents: N/A / \_\_\_\_\_

Fractures / Dislocations: N/A / \_\_\_\_\_

Surgeries: N/A / \_\_\_\_\_

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**Overall Health History:** (circle, highlight or write where applicable any *past or present* health challenges)

ADD / ADHD	Allergies	Arthritis	Asthma	Cancer
Constipation	Diarrhea	Diabetes	Digestive Issues	Epilepsy
Eating Disorder	Heart Disease	Herniated Disc	Migraines	Headaches
Learning Disorder	High Cholesterol	Pinched Nerve	Osteoporosis	Stroke
Repeat Infections	Frequent Colds	Fibromyalgia	Sinus Problems	Acid Reflux
Thyroid Problems	Tumor/Growth	Depression	RA	MS
Menstrual Problems _____	Sleeping Problems _____			

OTHER \_\_\_\_\_

Do you exercise: Yes No      How often: \_\_\_\_\_ Type: \_\_\_\_\_  
 Do you smoke: Yes No      How often: Daily Weekly Occasional  
 Do you drink caffeine Yes No      How often: Daily Weekly Occasional  
 Do you drink alcohol: Yes No      How often: Daily Weekly Occasional

List any allergies: No known / \_\_\_\_\_

Please rate the following as (P) Poor, (G) Good or (E) Excellent:  
 Diet – P G E      Sleep – P G E      Mental State – P G E      General Health – P G E

**Family History:**

Does anyone in your family suffer with any of the following conditions? (Please circle or highlight Father &/or Mother)

F M Heart Disease	F M Stroke	F M Cancer (types): _____
F M High BP	F M Thyroid	F M Neurological ( <i>Parkinson's, ALS, MS</i> ) other _____
F M Diabetes	F M Asthma	F M Other _____

Would you like to receive our health and wellness newsletter (1-2 times per month via email)? Yes No  
 (Topics include: diet, exercise, stress management, women's and children's health, wellness topics, etc.)

**Fees & Care Plans:**

Initial Exam	\$80
Adjustments	\$40
Re-Exam	\$50

On your second visit, Dr. Sullivan will review the results of your exam and go over your care plan. We will also review your financial responsibilities regarding your care. If you have insurance, please read the section below.

**Insurance:** We used to be 'in network' with many insurance companies; however, we found being 'out of network' offered most of our patients *better* coverage and *fewer* restrictions. Currently we are 'in network' with BC/BS & Medicare. We are considered 'out of network' for all others. You may call the (800) number on the back of your card to check your coverage; however, we will call to verify your chiropractic benefits and discuss them with you on your second visit when the doctor reviews your care plan.

**MEDICARE** – Medicare has limited chiropractic coverage; however, they **DO NOT** contribute towards the **initial exam or x-rays** in a chiropractic office. Your initial visit will most likely include the initial exam (\$80) and both sets of x-rays (\$140), for a total cost of \$220.

**MEDICAID** – Currently Medicaid DOES NOT offer ANY chiropractic benefits. The fees listed above will be your full financial responsibility if you have Medicaid or any Medicaid type policy.

I understand that I am directly and fully responsible to BC Family Chiropractic for all fees associated with chiropractic care whether or not paid by insurance. If I have insurance, I authorize and assign all insurance benefits payable to me for services rendered if BC Family Chiropractic accepts assignment on my behalf. I authorize use of my signature below on all insurance submissions. Copies of any x-ray reports will be released upon written request, however the original films are the legal property of this practice and that by law the doctor must retain these films for a period of no less than 7 yrs.

The above information is true and accurate to the best of my knowledge.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Dr. Initials

**Continued on back...**

# ACTIVITIES OF DAILY LIVING

In order to properly assess your condition, we must understand how much your health problems have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition currently.**

- 1) **Pain Intensity:** 0-----1-----2-----3-----4  
 None                      Mild                      Moderate                      Severe                      Unbearable
  
- 2) **Frequency of Pain:** 0-----1-----2-----3-----4  
 None                      25% of the day                      50% of the day                      75% of the day                      Constant
  
- 3) **Lifting:** 0-----1-----2-----3-----4  
 No Pain w/  
Heavy Weight                      Increased Pain  
w/ Heavy Wt.                      Increased Pain  
w/ Moderate Wt.                      Increased Pain  
w/ Light Wt.                      Increased Pain  
w/ Any Wt.
  
- 4) **Walking:** 0-----1-----2-----3-----4  
 No Pain w/  
Any Distance                      Increased Pain  
After 1 Mile                      Increased Pain  
After 1/2 Mile                      Increased Pain  
After 1/4 Mile                      Increased Pain  
w/ Any Distance
  
- 5) **Standing:** 0-----1-----2-----3-----4  
 No Pain After  
Several Hours                      Increased Pain  
After Several Hours                      Increased Pain  
After 1 Hour                      Increased Pain  
After 1/2 Hour                      Increased Pain  
w/ Any Standing
  
- 6) **Travel:** 0-----1-----2-----3-----4  
 (Driving)                      No Pain on  
Long Trips                      Mild Pain on  
Long Trips                      Moderate Pain  
on Long Trips                      Moderate Pain  
on Short Trips                      Severe Pain on  
Short Trips
  
- 7) **Work:** 0-----1-----2-----3-----4  
 Do Usual Work  
+ Unlimited Extra                      Do Usual Work  
But No Extra                      Can do 50%  
of Usual Work                      Can do 25%  
of Usual Work                      Cannot  
Work
  
- 8) **Sleeping:** 0-----1-----2-----3-----4  
 Perfect Sleep                      Mildly Disturbed                      Moderately Disturbed                      Severely Disturbed                      Totally Disturbed
  
- 9) **Personal Care:** 0-----1-----2-----3-----4  
 (Washing,  
Dressing, etc.)                      No Pain                      Mild Pain                      Moderate Pain                      Severe Pain                      Unbearable Pain
  
- 10) **Recreation:** 0-----1-----2-----3-----4  
 Can do All  
Activities                      Can do Most  
Activities                      Can do Some  
Activities                      Can do Few  
Activities                      Cannot do Any  
Activities

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Score: \_\_\_\_\_