Application for Care: Pregnant Patient *Brouse Wellness Chiropractic*

Name________________________________DOB______________________Date_________________
Home Phone _______________________Work Phone_________________Cell Phone__________________
Name of Husband________________________________Husband's Employment_____________________
Insurance Information____
Did a health problem prompt you to visit a chiropractor?_______Explain___________________________
____
____
Previous Major Illness or Surgery____
____
Medications your are currently taken or have taken since conception_______________________________
____
Allergies____
Do you smoke?______(If no, did you ever smoke)?_______How Long__________________________
Do you drink? None______Social (fewer than 2 daily)_______ Heavy (2 or more daily) ______________
List the foods you eat daily and summary of your diet habits____
____
____
What type of exercises do you do?____
____
Age at last menstrual cycle?________________ Length of regular menstrual cycle?____________________
Are your cycles regular? Always __________ Most of the time_____________Never___________________
Date of your last menstrual cycle___________________Was it nomal?______________________________
Date of last x-rays if any?______________Why and by whom?___________________________________
Have you had any previous pregnancies?______Explain____
____
Have you had past cesareans?_________________How many?_________________
Have you had a previous D&C?___________ How many and dates?_______________________________
Do you have any of the following?
Diabetes________Asthmas___________Rh negative blood___________Other chronic problems_______
Have you taken birth control pills?________ Type____
Have you used an IUD?_________Date of removal____
Did you have any health problems during previous pregnancies?____ Explain________________________
____
Have you receiver chiropractic care?__________Dr.'s Name?___________________________________
Results____
Who referred you to our office?____
Name of you obstetrician?_________________________Nurse/Midwife___________________________
Other____
Where do you plan to have your baby?____
What symptoms of pregnancy have you already experienced?_________________________________
____
Additional Comments ____
____
____