Family Chiropractic
204 Pinehurst Dr. SW #103
Tumwater, WA 98501

Dr. Betsy Burgos Diaz

Women's Health – Pregnancy
Chiropractic Intake form

Welcome to our office!! The following information is confidential. It will be used to complete your history and understand your condition, so please be as accurate as possible while completing this form. If you have any questions about this form, please ask at the front desk.

PATIENT INFORMATION Date ____/____/____

Patient Name ____
LAST FIRST MI

Address ____

City ________________________ State __________ Zip __________

Email ____

Cell Phone (_____)______________________ Work Phone (_____)______________________

Home Phone (_____)______________________ Best time to reach you ______________________

Date of birth ______/______/______ Age _______________ Sex Male Female

Married Single Dating Divorced Widowed

Occupation ____________________________ Employer/School ______________________________

IN CASE OF EMERGENCY, CONTACT

Name ________________________________ Relationship ________________________________

Primary Phone (_____)___________________ Secondary Phone (_____)________________________

REFERRAL INFORMATION

How did you hear about us? Facebook Family/Friend (Whom may we thank for referring you? _______________)
Internet Search Primary Physician Staff Other ____

Can we send them a thank you note for referring you to us? Yes No

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PATIENT CONDITION

Current Health Concern: ________________________________ When did this condition start? _____/_____/_____

Rate your pain on a severity scale from 1 (least) to 10 (severe) __________

Mark an X on the picture where you have symptoms.

Describe your symptoms Sharp Dull Aching Throbbing Burning Stabbing Swelling

Numbness Tingling Stiffness Other ___________________________________

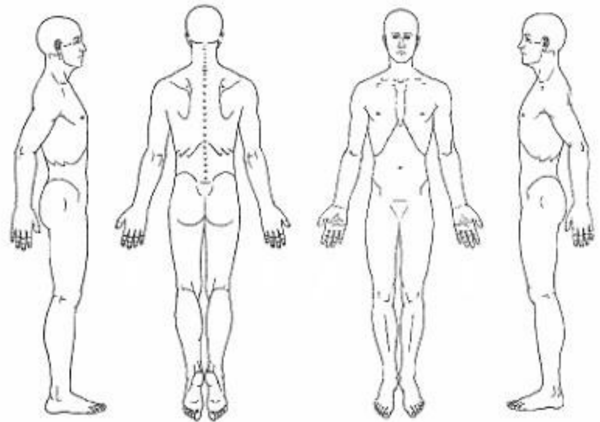
How often do you have this pain? Constant Frequently Intermittent Occasionally

Does this condition interfere with: Work Family Sleep Daily Activities

Sitting Standing Walking Bending Lying down

Have you experienced this problem before? No Yes

Please Explain ___________________________________



Have you sought treatment for this condition before? No Yes

Please Explain ___________________________________

What are your goals during and after treatment?

1.______________________________________ 2.______________________________________

3.______________________________________ 4.______________________________________

PREVIOUS TREATMENT

Family Medical Doctor:______________________________________ Date of last visit_____/_____/_____

Previous Chiropractic Care No Yes Name:_________________________ Date of last visit_____/_____/_____

What treatment have you already received for you condition? Acupuncture Chiropractic Massage

Medications Physical Therapy Surgery None Other _______________________________

Previous Diagnosis ___________________________________ Last X-Rays Taken _____/_____/_____

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PREVIOUS INJURIES

Please describe any injuries or surgeries (e.g., slips/falls, head injuries, broken bones, dislocation, surgeries, auto accidents)

____

____

____

HEALTH HISTORY

Please mark any of the following conditions that you have been diagnosed with or experience

AIDS/HIV	Dizziness	Nausea
Alcoholism	Eating Disorder	Night Sweats
Allergies (List: _________________)	Epilepsy	Mood swings, irritability
Anemia	Excessive Thirst	Osteoporosis
Arthritis	Fainting	Pacemaker
Asthma	Fatigue	Pinched nerve
Bleeding disorder	Fever	Pneumonia
Breast Lump (s)	Prostate problems	Ringing in the ears
Balance problems*	Pelvic inflammatory Disease	Seizures/convulsions
Blood pressure – High - Low	Fractures	Sleep problems
Fainting	Fatigue	Temperature intolerance*
Cancer*	Headaches	Shortness of breath
Circulatory problems	Heartburn	Stroke
Cholesterol – High – Low	Heart problems*	Thyroid problems*
Congenital Disease*	Hernia	Tuberculosis
Depression	Herniated Disc*	Tumor (s)*
Diabetes – Type I – Type II	Hypertension	Unexplained weight-loss
Diarrhea	Kidney Disease	Visual problems*
Digestive problems	Liver Disease	Vomiting
Ear infection	Miscarriage	Vertigo/dizziness
Body pain*	Mononucleosis	Sore throat
Headaches	Night sweats	Chest pain
Jaundice	Hemorrhoids	Hot flashes
Pain with bowel movement	Fibroids	Numbness legs or arms*
UTI	Chronic yeast infection	Scoliosis
Liver problems*	Hip pain	Increase PMS
Polycystic Ovary Syndrome (POS)	Painful menstrual cycles	Changes in menstrual cycle

OTHER(s)____

*Explain____

____

____

Are you taking any medications or drugs? Yes No

Please List____

Are you taking any vitamins/supplements/herbs/minerals? Yes. No

Please List____

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SOCIAL HISTORY

Mark all that applies

EXERCISE	WORK ACTIVITY	HABITS	
None	Sitting	Smoking	Packs/day______________
Moderate	Standing	Alcohol	Drinks/week____________
Daily	Light Labor	Caffeine	Cups/day______________
Heavy	Heavy Labor	High Stress Level	
	Other________________	Reason__________________________	

PREGNANCY QUESTIONNAIRE

PREVIOUS BIRTH EXPERIENCE

Is this your first pregnancy? No Yes

If not, please tell us about your previous pregnancy and/or birth experience(s). (Duration, interventions, etc)

____
____
____

Do you plan to follow the same plan as your previous delivery? Yes No

If not, what would you like to change? ____

____

CONCEPTION & EARLY PREGNANCY

When is your expected/calculated due date? ______________ What week of pregnancy are you currently in?_____________

Pre-pregnancy weight?______lbs. Current weight?________lbs. Gender? Girl Boy

Did you have any difficulty conceiving? No Yes If yes, please explain_______________________________________

Have you ever used any form of hormonal or oral contraceptives? Yes No

If yes, which ones, and for how long?____

Have you experienced morning sickness? No Yes

If yes, please explain____

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CURRENT HEALTH CONDITIONS

What type of exercise(s) are you currently peforming?______________________________

Have you taken any medications or supplements during your pregnancy? Yes No

If yes, please explain______________________________

Please tell us about current diet, and any dietary restrictions ______________________________

____

Have you had any slips, falls, or other physical traumas during pregnancy? No Yes

If yes, please explain______________________________

Are you experiencing any pain? Please describe______________________________

CURRENT HEALTH CONDITIONS (cont…)

Please mark any of the following conditions that applies

Depression	Dizziness	Nausea
Headaches	Fever	Night sweats
Numbness	Blood Pressure – High – Low	Pinched Nerve

PRE/POST BIRTH PLAN

What are your top 3 goals for this pregnancy?

1.______________________________

2.______________________________

3.______________________________

Goals for chiropractic care during pregnancy?

* ______________________________
* ______________________________
* ______________________________

Check the following that will be present for delivery: OB/GYN Midwife Doula Other__________

Location of birth______________________________

Do you plan on breastfeeding? Yes No

Are you taking any pre-natal or birthing classes? No Yes

Is there anything else you would like to tell us about your pregnancy or birth plan? ______________________________

____

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Office Policies

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. ____________(initials)

In the event that you are not able to keep your scheduled appointment, please give 24 hours' notice prior to canceling. Canceling with less than 24 hours' notice or missing an appointment will result in. being charged the cost of the appointment________(initials)

NOTICE OF PRIVACY PRACTICE *We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us or the law authorizes or compels us to do so. You may see your records to get information about it by contacting our office at (360) 352-8112. Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed and how you may access your information. ___________(initials)*

Informed Consent

The Doctor of Chiropractic evaluates the patient using standard examination and testing procedures. If your history and examination indicate the need, you will receive further diagnostic tests or a referral to a specialist. A chiropractic adjustment involves the application of a quick, precise force directed over a very short distance to a specific vertebra or bone. Adjustments are usually performed by hand but may also be performed by hand-guided instruments or equipment. In addition to adjustments, other treatments used by chiropractors include soft tissue manipulation, nutritional recommendations, and exercise. Please list any preferences here____

I have read the previous information regarding the risk of chiropractic care, and my doctor has verbally explained the risks (if any) and suggested alternatives when those risks exist. I understand the purpose of care and have been explained the treatment, the frequency of care, and alternatives to this care. All my questions have been answered to my satisfaction. I agree to this plan of care, understanding any perceived risk(s) and alternatives to this care for the above minor patient. By signing, I give consent for examination, tests, and procedures for the above minor patient. _____________(initials)

By signing, I have read and understood the Office Policies and Informed Consent:

Print Patient Name ____

Print Parent/Guardian Name ____

Parent/Guardian Signature____ Date ______/______/______