

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

*Dr. Betsy Burgos Diaz*



***Women's Health - Postpartum***  
***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



**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

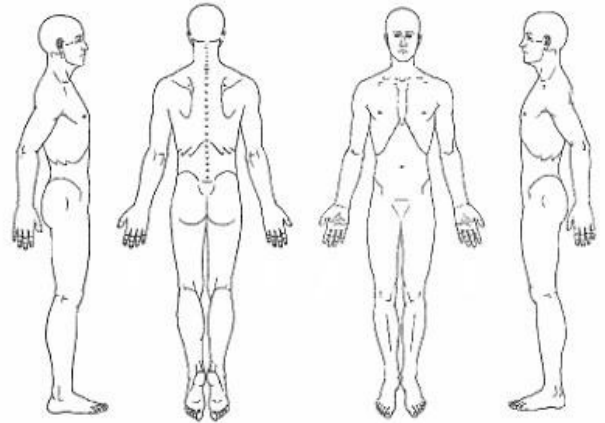
Sitting  Standing  Walking  Bending  Lying down

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 \_\_\_\_/\_\_\_\_/\_\_\_\_



**PREVIOUS INJURIES**

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

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**HEALTH HISTORY**

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

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



**SOCIAL HISTORY**

Mark all that applies

**EXERCISE**

- None
- Moderate
- Daily
- Heavy

**WORK ACTIVITY**

- Sitting
- Standing
- Light Labor
- Heavy Labor
- Other \_\_\_\_\_

**HABITS**

- Smoking Packs/day \_\_\_\_\_
- Alcohol Drinks/week \_\_\_\_\_
- Caffeine Cups/day \_\_\_\_\_
- High Stress Level Reason \_\_\_\_\_

**POSTPARTUM QUESTIONNAIRE**

**BIRTH EXPERIENCE**

Date of birth? \_\_\_\_\_ How many weeks pregnant at the time of birth? \_\_\_\_\_ Baby's weight? \_\_\_\_\_

Was this your first pregnancy?  Yes  No If not, how many pregnancies? \_\_\_\_\_ Births? \_\_\_\_\_

Was this natural or IVF pregnancy?  Natural  IVF

Location of birth? \_\_\_\_\_ Did you go into active labor? \_\_\_\_\_ How long was labor? \_\_\_\_\_

Did you have a vaginal birth?  Yes  No Scheduled C-section?  Yes  No Unplanned C-section?  Yes  No

Epidural?  Yes  No Was labor increased with Pitocin?  Yes  No

In your own words, please describe how you feel about your labor experience \_\_\_\_\_

**EMOTIONAL & PHYSICAL HEALTH**

Do you have a partner or support person/system living with you?  Yes  No

Do you have a postpartum doula?  Yes  No

Are you seeking care from:  Pelvic Floor PT  Acupuncture  Other Provider? \_\_\_\_\_

Have you had any major emotional stresses during pregnancy or since baby's birth?  Yes  No

If yes, please explain \_\_\_\_\_

Did you experience any complications in birth?  Pelvic Tear  Forceps  Excessive Bleeding  Abnormal heartrate

Umbilical cord issues  Failure to progress  Malposition of baby  Placenta issues

Others \_\_\_\_\_



**CURRENT HEALTH CONDITIONS**

Are you lactating? \_\_\_\_\_ Do you have any questions or concerns about the baby's feeding or latching?  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 since birth?  No  Yes

If yes, please explain \_\_\_\_\_

Please mark any of the following conditions

- |                                     |  |  |
|-------------------------------------|--|--|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Dizziness                   | <input type="checkbox"/> Nausea        |
| <input type="checkbox"/> Headaches  | <input type="checkbox"/> Fever                       | <input type="checkbox"/> Night sweats  |
| <input type="checkbox"/> Numbness   | <input type="checkbox"/> Blood Pressure – High – Low | <input type="checkbox"/> Pinched Nerve |

Are you experiencing any pain? Please describe \_\_\_\_\_

**PRE/POST BIRTH PLAN**

What are your top 3 goals for the first three months postpartum?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Goals for chiropractic care during postpartum phase?

- \* \_\_\_\_\_
- \* \_\_\_\_\_
- \* \_\_\_\_\_

How can we assist your postpartum goals? \_\_\_\_\_

**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)

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**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** \_\_\_\_ / \_\_\_\_ / \_\_\_\_