RCW Postpartum New Patient Paperwork

Adult Patient Questionnaire

1. CONFIDENTIAL PATIENT INFORMATION:1

First Name: _____ Last Name: _____ DOB: _____ Gender: ○ M ○ F

Marital Status: ○ Single ○ Married ○ Divorced ○ Widowed

# of Children: _____

Street Address: _____ Apt./Unit #: _____ Occupation: _____

City: _____ State: _____ Zip Code: _____ Email: _____

Cell Phone: _____ Other Phone: _____

2. Emergency Contact: _____ Emergency Relation: _____ Emergency Phone: _____

3. How did you hear about us? (please select all that apply & list who in the box that appears)

☐ Current Patient (list who) _____

☐ Professional Referral/Doctor (list who) _____

☐ Google Search _____

☐ Social Media (list platform) _____

☐ Community Partner (list who) _____

☐ Other (specify) _____

4. Who is your primary care physician? _____ Date of your last visit: _____

Reason for your last doctor visit: _____

5. Are you also receiving care from any other health professionals?

○ Yes ○ No

6. If yes, please name them and their specialty:

	Name	Specialty
1		
2		
3		

7. Please note any significant family medical history:

_____

_____

_____

_____

CURRENT HEALTH CONDITIONS

8. What health condition(s) bring you into our office?

_____

_____

_____

_____

9. Have you received care for this problem before?

○ Yes ○ No

If yes, which types of care? Please list

_____

10. When did the conditions first begin?

_____

How did the problem start?

○ Suddenly ○ Gradually ○ Post-Injury

Is this condition:

○ Getting worse ○ Improving ○ Intermittent ○ Constant ○ Unsure

What makes the problem better?

_____

What makes the problem worse?

_____

YOUR HEALTH GOALS

11. Your top three health goals:

1. _____

2. _____

3. _____

CHIROPRACTIC HISTORY

12. What would you like to gain from chiropractic care?

- ○ Resolve existing challenge
- ○ Overall wellness
- ○ Both

13. Have you ever visited a chiropractor?

- ○ Yes
- ○ No

If yes, which practice(s)?

_____

14. What is their specialty?

- ○ Pain Relief
- ○ Physical Therapy & Rehab
- ○ Nutritional
- ○ Subluxation-based
- ○ Other

If other, specify:

_____

15. Do you have any chiropractic concerns for other family members today?

_____

_____

_____

_____

TRAUMAS: Physical Injury History

16. Have you ever had any significant falls, surgeries or other injuries as an adult?

- ○ Yes
- ○ No

If yes, please explain:

_____

17. Notable childhood injuries?

○ Yes ○ No

If yes, please explain:

_____

18. Youth or college sports?

○ Yes ○ No

If yes, list major injuries:

_____

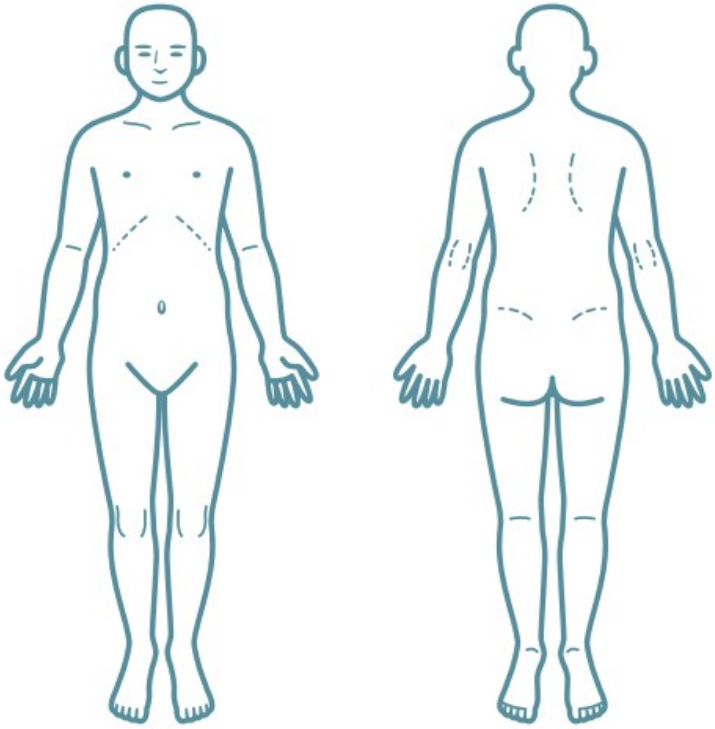
19. Any auto accidents?

○ Yes ○ No

If yes, please explain:

_____

20. *Please indicate where you are experiencing pain or discomfort.*



21. Exercise Frequency?

○ None ○ 1-2x per week ○ 3-5x per week ○ Daily

What types of exercise?

_____

22. How do you normally sleep?

○ Back ○ Side ○ Stomach

Do you wake up:

○ Refreshed and ready ○ Stiff and tired

23. Do you commute to work?

○ Yes ○ No

If yes, how many minutes per day?

_____

24. List any problems with flexibility (ex. Putting on shoes/socks, etc.):

_____

_____

_____

_____

25. How many hours per day you typically spend sitting at a desk or on a computer, tablet or phone?

_____

TOXINS: Chemical & Environmental Exposure

26. Please rate your CONSUMPTION for each:

	1 - None	2	3 - Moderate	4	5 - High
Alcohol					
Water					
Sugar					
Dairy					
Gluten					
Processed Foods					
Artificial Sweeteners					
Sugary Drinks					
Cigarettes					
Recreational Drugs					

27. Are you taking any medications?

○ Yes ○ No

If yes, please list which and why:

_____

28. Are you taking any vitamins or supplements?

○ Yes ○ No

If yes, please list which and why:

_____

THOUGHTS: Emotional Stresses & Challenges

29. Please rate your STRESS for each:

	1 - None	2	3 - Moderate	4	5 - High
Home					
Work					
Life					
Money					
Health					
Family					

30. Are there other emotional stresses or challenges you'd like to tell us about?

_____

_____

_____

_____

Patient Review of Systems

The nervous system controls and coordinates all organs and structures of the human body.

Please check the corresponding boxes for each symptom or condition you have experienced - including both past and present.

31.

	Past	Present
Anxiety & Constant Stress		
Focus & ADHD Challenges		
Difficulty Sleeping		
Low Energy and Fatigue		
Depression and Mood Regulation Challenges		
Lightheadedness & Dizziness		
Vertigo		
Tension Headaches		
Migraines		

Stiff Neck & Shoulders		
Pain, Numbness, & Tingling in Arms and Hands		
TMJ and Jaw Pain		
Vision & Hearing Issues		
Ear & Sinus Infections		
Sore Throat and Strep		
Strep & Upper Respiratory Infections		
Allergies and Autoimmune Challenges		
Chronic Inflammation		
Acid Reflux, GERD, & Indigestion		
Poor Metabolism & Weight Control		
High Blood Pressure		
Asthma		
Chronic Chest Colds & Cough		
Bronchitis & Pneumonia		
Functional Heart Conditions		
Gallbladder Pain & Issues		
Stomach Ulcers and Pain		
Blood Sugar Problems		
Skin Conditions / Rash		
Ulcerative Colitis		
Crohn's Disease		
IBS		
Kidney Challenges		
Gas Pain & Bloating		
Gluten & Casein Intolerance		
Constipation		
Bladder & Urination Issues		
Cysts & Endometriosis		
Fertility Challenges		
Erectile Dysfunction		
Hemorrhoids		
Low Back Pain & Stiffness		

Sciatica & Radiating Pain		
Lumbopelvic / SI Joint Pain		
Disc Degeneration		
Leg Weakness & Cramps		
Restless Legs		
Poor Circulation & Cold Feet		
Weak Ankles & Arches		

32. Date of birth?

How many weeks pregnant at time of birth?

33. Was this your first pregnancy?

- ○ Yes
- ○ No

If yes, how many pregnancies? Births?

34. Where did you give birth:

- ○ At home
- ○ At a Birth Center
- ○ At a Hospital
- ○ Other

Name of birth provider:

Which birth center/hospital?

If other, tell us more:

35. Did yo go into active labor?

How long was labor?

36. How long did you actively push?

37. Any interventions? Please check all

- ☐ Episiotomy
- ☐ Epidural
- ☐ Pitocin/induction
- ☐ Pelvic tearing
- ☐ Malposition of baby
- ☐ Magnesium drip
- ☐ Forceps
- ☐ Homeopathy medication
- ☐ Failure to progress
- ☐ Umbilical cord issues
- ☐ IV
- ☐ Vacuum
- ☐ Placenta/bleeding issues
- ☐ C-section

38. Tell us about what happened in the first hour after birth (Golden Hour)

- ○ Skin on Skin Right Away
- ○ Delayed Cord Clamping
- ○ Breastfeeding Initiation
- ○ Baby was with mom during the full hour
- ○ Hemorrhaging
- ○ Placental Delivery Challenges
- ○ Vitamin K Shot
- ○ Eye Ointment (Erythromycin)
- ○ NICU Transfer
- ○ Calm Environment
- ○ Hectic Environment
- ○ Other (please explain below)

Please elaborate on options chosen above. (Time, Quality, etc)

_____

39. In your words, please describe how you feel about your labor and birth experience:

_____

_____

_____

_____

CURRENT HEALTH CONDITIONS

40. List of Supplements:

	Supplements:	Dosage:	Frequency:	Reason for use:
1				
2				
3				

41. Are you currently seeing a Pelvic Floor Physical Therapist or planning to?

- ○ Yes
- ○ No
- ○ No, but I want more information

42. Have you returned to exercise?

- ○ No
- ○ Yes
- ○ Waiting to be cleared

43. How are you and your baby sleeping?

- ○ Bedsharing
- ○ Bedside Bassinet
- ○ In a separate room
- ○ Other (Please explain below)

Tell us more if necessary

_____

44. Are you baby wearing?

- ○ Yes
- ○ No
- ○ Will in the future
- ○ Would like to learn more

Tell us more if necessary

45. Are you lactating?

46. Is there any difficulty latching? Do you have any questions about your baby's feeding or latching?

47. How is baby receiving their nutrients?

- ○ Exclusively Breastfeeding
- ○ Breastmilk from mom & bottle
- ○ Breastmilk from bottle exclusively
- ○ Breastmilk & Formula
- ○ Exclusively formula fed

Tell us more if necessary

48. What are your top three goals for fourth trimester?

1.

2.

3.

49. Goals for chiropractic care during fourth trimester?

1.

2.

3.

SOCIAL MEDIA

50. Do you follow us on social media @rochesterchiro? Check all that apply:

- ☐ Instagram
- ☐ Facebook
- ☐ None yet, but i will

ACKNOWLEDGEMENT & CONSENT

51. Patient Name:

_____

_____ _____

Signature Date