RCW Pregnancy New Patient Paperwork

Pregnant 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 ______

☐ Facebook ______

☐ 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, please describe the type of care:

____

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

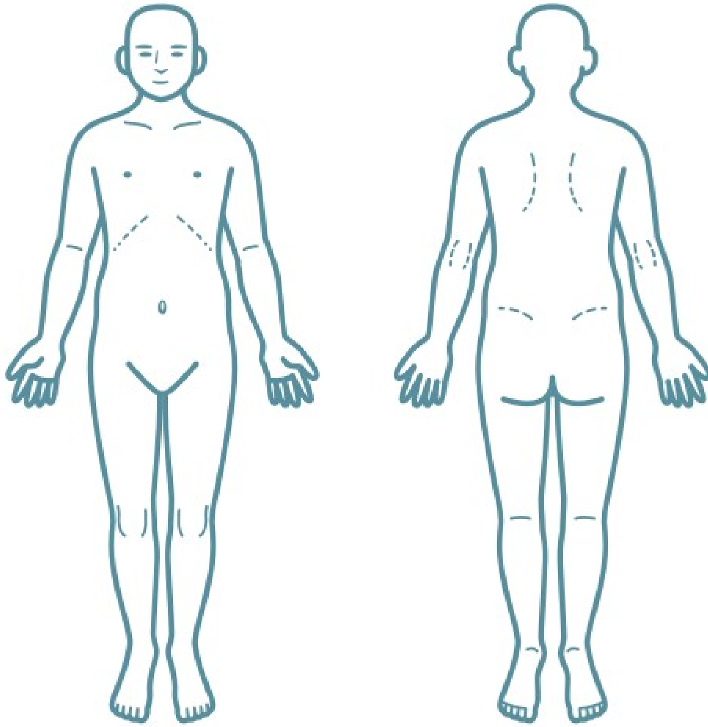
What makes the problem better?

____

What makes the problem worse?

____

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



YOUR HEALTH GOALS

12. Your top three health goals:

1. ______________________________
2. ______________________________
3. ______________________________

CHIROPRACTIC HISTORY

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

○ Resolve existing challenge ○ Overall wellness ○ Both

14. Have you ever visited a chiropractor?

○ Yes ○ No

If yes, what is their name?

____

15. What is their specialty?

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

If other, specify:

____

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

____

TRAUMAS: Physical Injury History

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

- Yes
- No

If yes, please explain:

____

18. Notable childhood injuries?

- Yes
- No

If yes, please explain:

____

19. Youth or college sports?

- Yes
- No

If yes, list major injuries:

____

20. Any auto accidents?

- Yes
- No

If yes, please explain:

____

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

28. If yes, please list which and why:

____
____
____
____

29. Are you taking any vitamins or supplements?

○ Yes ○ No

30. If yes, please list which and why:

____
____
____
____

THOUGHTS: Emotional Stresses & Challenges

31. Please rate your STRESS for each:

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

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

___

Pregnancy Questionnaire

33. Previous Birth Experience:

Is this your first pregnancy?

○ Yes ○ No

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

___

35. Do you plan to follow the same as your previous delivery?

○ Yes ○ No

36. If no, what would you like to change?

___

Conception and Early Pregnancy

37. When is you expected or calculated due date?

___

38. Did you have any difficulty conceiving?

○ Yes ○ No

If yes, please explain:

___

39. Have you used any hormonal or oral contraceptive?

- ○ Yes
- ○ No

40. If yes, which ones, and for how long?

____

41. When was your last menstrual cycle? ______________ What was you pre-pregnancy weight? ______________ Current weight? ______________

42. Have you experienced morning sickness?

- ○ Yes
- ○ No

Current Health Conditions

43. What type of exercise(s) are you currently performing?

____

44. Please tell us about your current diet, and any dietary restrictions.

____

45. Have you had any slips, falls, or other physical traumas during the pregnancy?

- ○ Yes
- ○ No

If yes, please explain:

____

46. Have you had any major emotional stressors during your pregnancy?

- ○ Yes
- ○ No

If yes, please explain:

____

Your Birth Plan

47. Your top three goals for this pregnancy:

1. ______________________________
2. ______________________________
3. ______________________________

48. Do you currently have any birth plan?

- Yes
- No

If yes, please explain: ______________________________

49. Are you taking any pre-natal or birthing class?

- Yes
- No

If yes, please explain: ______________________________

50. Who is your OB/GYN or midwife? ______________________________

Will they be present for delivery?

- Yes
- No

Who is you birth provider? ______________________________

51. Do you intend to have a doula or birth coach present?

- Yes
- No

If yes, please explain: ______________________________

52. Do you wish to have a natural vaginal labor and delivery?

- Yes
- No

53. If not, what concerns do you have? ______________________________

Your Post-Birth Plan

54. Do you plan on breastfeeding your child?

- Yes
- No

55. What do you intend to do for vaccines? ______________________________

56. Is there anything else you'd like to tell us about your pregnancy or birth plan? ______________________________

57. What would you like to gain from chiropractic care during your pregnancy? ______________________________

58. Are there any other questions you want to ask us? ______________________________

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.

59.

	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		
Stick 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		

ACKNOWLEDGEMENT & CONSENT

60. Patient Name:

____

______________________________ Signature

______________ Date