**Wellness for You Now Chiropractic** **Dr. Joseph Manza DC, CACCP**

Chiropractic care throughout pregnancy is essential to ensure a safer, easier birth process for mom and baby. More and more birth practitioners are recommending that their mothers receive chiropractic care throughout pregnancy. You've made an excellent decision ☺.

## Pregnancy Health History

GENERAL INFORMATION: **Today's Date:**_____

Full Name: _____ Age: _____ DOB: _____

Home#: (____)_____Cell #: (____)_____Work#: (____)_____

E-mail Address: _____

Home Address: _____ City: _____ State: ____ Zip: _____

Employer:_____Position/Duties_____

Marital Status: S M D W Name of Spouse: _____

Names and Ages of Children: _____

Do you have any x-rays prior to being Pregnant? If so where_____

Have you ever received chiropractic care? Yes No With whom? _____

Emergency Contact: _____ Phone #: (____)_____

Whom may we thank for referring you? _____

**Prenatal history:**

Is this your first pregnancy? Yes No If No, how many?_____
How many live births have you had? _____
How many weeks pregnant are you now? _____

Have you experienced any traumas during this pregnancy? Yes No
If Yes please comment:_____

Have you taken medications during this pregnancy? Yes No
If yes, please describe: _____

Do you smoke or drink alcohol? Yes No If yes, describe_____

Have you had any evaluation procedures (ultrasound, amniocentesis, chorionic villus sampling)? Yes No If yes, please list dates, frequency and reasons:

_____

_____

How has your diet been during this pregnancy? _____

Have there been any stressful events in your life during this pregnancy? Yes No
If yes, please comment: _____

What, if any, are your most significant concerns associated with this pregnancy/birth?
_____

Who is your birth care provider? _____

Will you have someone with you at birth for support (other than birth care provider)?
Yes No Comment: _____

Where do you plan on delivering? Home or Hospital. Which hospital?_____

Have you put together a birth plan? Yes No

**Previous Birth History (if applicable):**
Place of birth**:** ____ Home ____ Birthing center ____ Hospital
Delivering Practitioner**:** ____ Lay Midwife ____ Nurse Midwife ____ OB/Gyn
Position of Delivery: ____ Squatting ____ Lithotomy position (on back with feet up)
____ On Your Side ____ Kneeling Other _____
Was labor induced? Yes No Unknown
Did your care provider rupture your membranes? Yes No Unknown
Did you receive any pain medications or anesthesia? Yes No Unknown
If yes, please specify type used_____
Did you receive an epidural? Yes No If yes, how many_____
Did you experience back pain during labor? Yes No Unknown
Did you deliver vaginally? Yes No
Baby presentation at time of delivery:__ Normal __ Posterior __ Brow __ Facial __ Breech
If breech, specify type: ____Footling____ Frank ____ Complete ____Kneeling

Did your care provider assist delivery with his/her hands? Yes No Unknown
Was there any turning of the neck, or traction applied to the neck? Yes No Unknown

Were operative devices used to facilitate the birth? Yes No Unknown
If yes, which type? ____ Forceps ____ Vacuum Extraction

Was there any visible injury to your baby? Yes No Unknown
If so, where on your baby was the injury sustained? _____

Was there a birthing coach present? ____ Husband____ Doula____Friend Other _____
At what week of pregnancy was your baby born? _____

Any other important information:_____
_____
_____
_____
_____
_____

**Present State of Health (Presenting Symptoms).** Most pregnant women visit our office to give themselves and their baby the best opportunity to have a healthy birth process. However, some women also experience symptoms during their pregnancy. If you have a specific concern please complete the following section as this vital information will help Dr. Joe understand your current concern and subluxation pattern. A subluxation occurs when your spine does not move properly, placing dangerous pressure on your spinal nerves which connect your brain to your body.

**1)** WHEN & HOW did your current complaint begin?_____
_____

**2)** Please circle one: Is your concern **new (acute)** or **old (chronic)**?

**3)** What time of day is your complaint better?_____

**4)** What time of day is your complaint worse?_____

**5)** What makes your complaint better?_____

**6)** What makes your complaint worse?_____

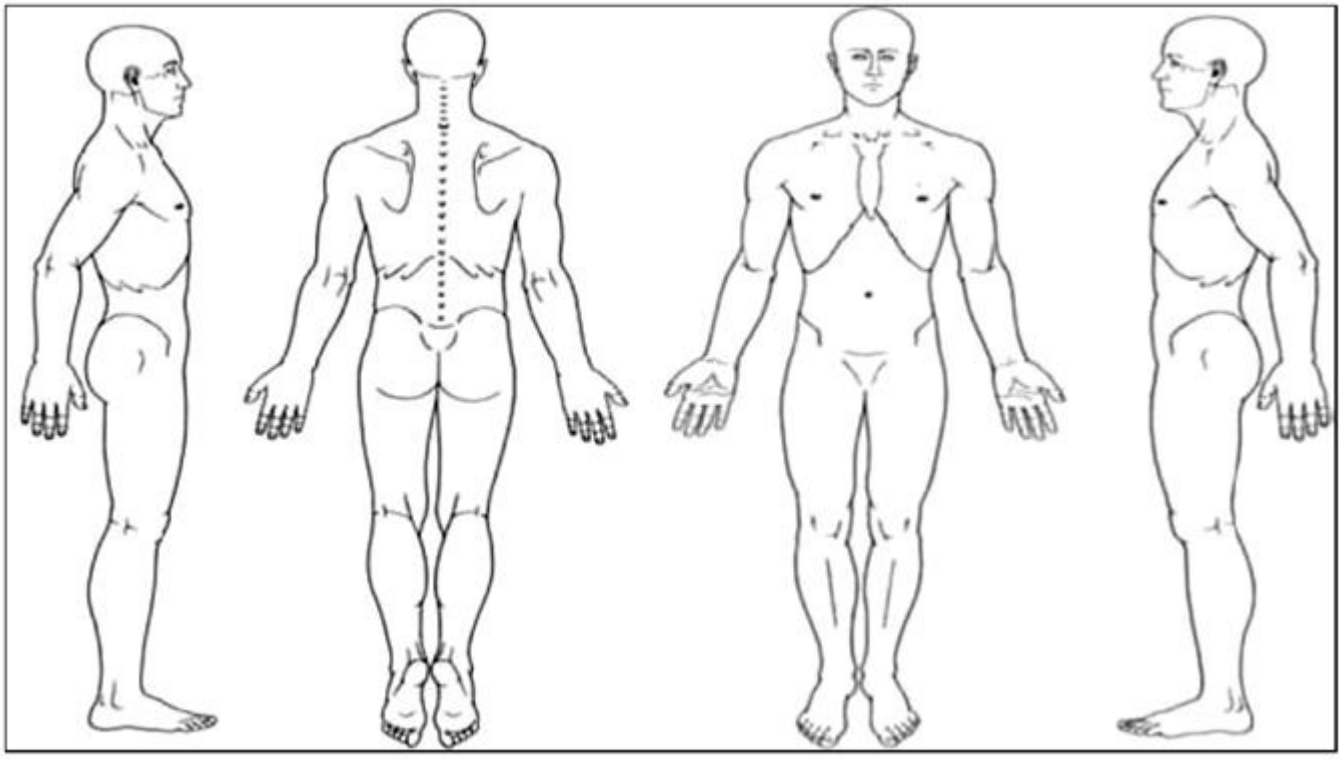
**7)** Does your complaint worsen if you cough/sneeze/push to move your bowels?_____

**8)** What other healthcare professionals have you consulted for your complaint?_____
What care was provided?_____

**9)** Please circle any and all symptoms that best fit your current concern:
Sharp Dull Ache Numb Shooting Burning Tingling Crampy

**10)** Please mark where you feel your concerns on the diagram below.

**11)** Rate your current level of symptoms on a 0-10 scale. (0 = none, 10 = worst) Symptom Level ____



**12)** Please circle one: If you are having symptoms, how often do you experience your symptoms?
All of the time: (76-100% of the day) Most of the time: (51-75% of the day)
Some of the time: (26-50% of the day) A little bit: (up to 25% of the day)

**13)** How are your concerns changing? Getting Better Not Changing Getting Worse

**14)** How much have your concerns interfered with your lifestyle? (Please circle one)
Not at all A little bit Some of the time Most of the time All of the time

**15)** How would you rate your current overall health: Poor Fair Good Very Good Excellent

The information I have written is accurate and true. Sign _____Date_____