

CASE HISTORY FOR PREGNANT PATIENT

Patient Name: _____ Date of Birth: ____/____/____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer name & address: _____ Occupation: _____

Spouse's name: _____ Spouse's Employer: _____

Children's names and ages: _____

Did a health problem prompt you to visit a chiropractor? ____Y ____N Explain: _____

Previous Major Illnesses or Surgeries: _____

Medications you are currently taking or have taken since conception: _____

Allergies: _____

Do you smoke: ____Y ____N If no, did you ever smoke? ____Y ____N How long? _____

Do you drink? ____None ____Social (fewer than 2/day) ____Heavy (more than 2/day)

List the foods you eat daily and a summary of your diet habits _____

What type of exercises do you do: _____

Age at last menstrual cycle? _____ Date of last menstrual cycle? ____/____/____ Length of regular menstrual cycle? _____

Are your cycles regular? ____Always ____Most of the time ____Never

Date of last X-Ray, if any" ____/____/____ Why and by whom? _____

Have you and any previous pregnancies? ____Y ____N Explain: _____

Have you had any past cesareans? ____Y ____N How many? _____

Have you had any previous D & C's? ____Y ____N How many and dates: _____

Do you have any of the following...

Diabetes ____Y ____N Asthma ____Y ____N Rh negative blood ____Y ____N Other chronic problems ____Y ____N

Have you taken birth control pills ____Y ____N Type? _____ Have you used an IUD? ____Y ____N Date removed _____

Did you have any health problems during previous pregnancies? ____Y ____N Explain: _____

Have you ever received chiropractic care? ____Y ____N Previous chiropractor: _____

Results: _____

Whom may we thank for referring you? _____

Name of your obstetrician: _____ Nurse/Midwife: _____

Where do you plan to have your baby? _____

What symptoms of pregnancy have you experienced? _____

Additional comments: _____

Have you had the same or similar problem(s) before? _____ Yes _____ No

How Long?: _____ Please Explain: _____

Father/Mother/Brother/Sister/Children, with similar problems? _____

Is this the result of an auto or work injury? _____ If so, when? _____

If this is a work injury, is there a panel chiropractor that your company's Worker's Compensation

Insurance requires you to see in the first 90 days? If so, please list their name.

Other Doctors who have treated this problem: _____

Surgery you have had: _____

Medication(s) you currently take: _____

Is there any chance you are pregnant? Yes _____ No _____

What have you heard about chiropractic? _____

Do you know what a subluxation is? _____ If yes, please describe _____

What daily rituals for spinal health do you presently practice? _____

Have you ever been diagnosed with cancer? _____ If so, what kind? _____

Do you have health insurance? _____ Name of Company: _____

I.D. # _____ Group # _____

Name of Insured _____

Method of Payment for First Visit: _____ Cash _____ Check _____ Credit Card

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. If I fail to pay for services rendered and you are required to institute collection proceedings, I agree to pay for reasonable attorney's fees and costs in attempting to collect the balance. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature _____ Date _____

Guardian or Spouse's Signature _____