PREGNANCY NEW PATIENT HISTORY

Date: ______________
Doctor: ______________
Number: ______________

Full Name: ____

Date of Birth: ______________________ Age: __________________

Home Address: ____

Contact Number: __________________ Email: ______________________________

Occupation: _______________________

Husband/Partner & Children's names: ______________________________

Concession Card: ______________________ Expiry Date: ______________________

Medical Doctor: ____________________ Obstetrician / Midwife: ____________________

Emergency Contact: ___________________

How did you hear about this clinic? ______________________________________

How many weeks pregnant are you? ____________

Number of pregnancies: ________________________ Number of Children: __________________

Have you experienced difficulties in previous pregnancies/labours & was medical intervention necessary?

Yes / No Please Explain:

____

____

____

Main reason for visit? ____

Have you had Chiropractic before? Y / N Where? ______________________________

What other treatment have you had? ______________________________________

What caused the current complaint? ______________________________________

What makes it better / worse? ______________________________________

Any hospitalisations / surgeries? (date & reason) ______________________________

____

Have you had any car accidents or major trauma? ______________________________

____

Is there anything else we should know? ______________________________________

____

Current Medications/Supplements

Product name	Prescribed by	Dose ml/tab	X day

Have you experienced any of the following?

Allergies?	Y | N	Falls or Accidents?	Y | N
Arthritis?	Y | N	High blood pressure?	Y | N
Asthma?	Y | N	Gestational Diabetes?	Y | N
Anxiety?	Y | N	Anemia?	Y | N
Bladder Condition?	Y | N	Fatigue & Lethargy?	Y | N
Dizziness?	Y | N	Morning Sickness?	Y | N
Depression?	Y | N	Indigestion?	Y | N
Heart condition?	Y | N	Seizures?	Y | N
Joint condition?	Y | N	Swollen Ankles?	Y | N
Ligament condition?	Y | N	Thyroid Problems?	Y | N
Headaches/Migraines?	Y | N	Abnormal Bleeding?	Y | N
Food Cravings?	Y | N	Hospitalisations?	Y | N
Back Pain?	Y | N	Multiple Ultrasounds?	Y | N
Stress during pregnancy?	Y | N	Other Illnesses?	Y | N

What is your stress level (0= none, 10= max) 1.....2.....3.....4.....5.....6.....7.....8.....9.....10

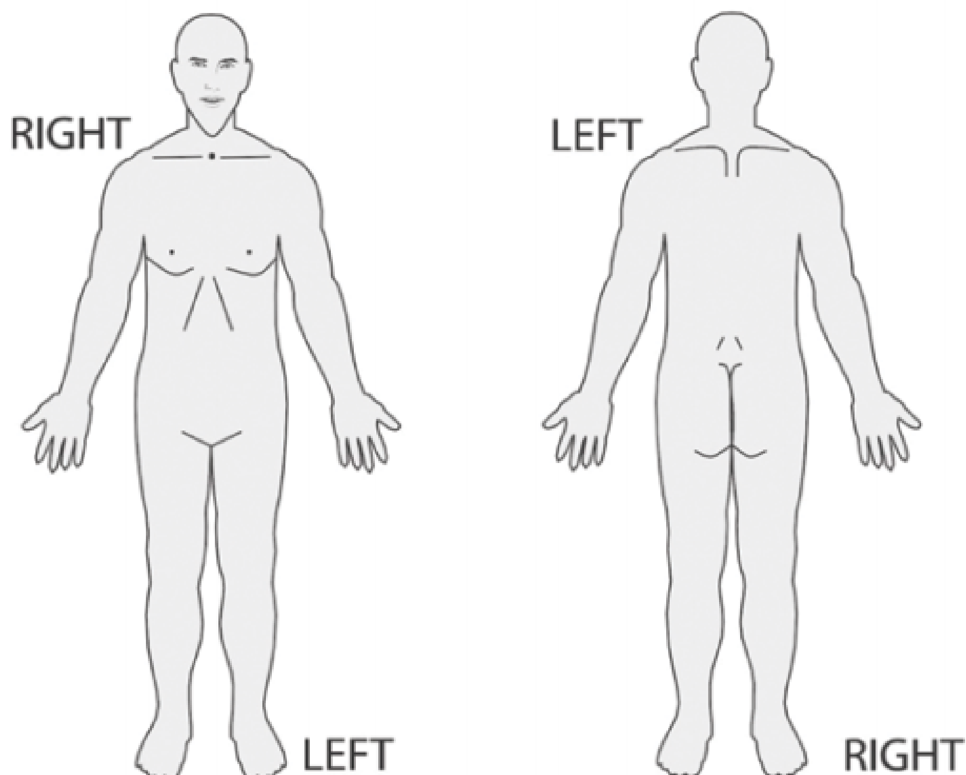
What is your energy level (0= none, 10= max) 1.....2.....3.....4.....5.....6.....7.....8.....9.....10

Do you suffer from cramps? (Yes/No)

Do you suffer from numbness? (Yes/No)

Do you suffer from pins and needles? (Yes/No)

Please mark any areas of discomfort and pain on the diagram.



Exercise

How often have you exercised this month? ____
What type of exercise? ____
Do you use a trigger point ball or roller? ____

Context of Care

How long do you think it will take to get your health to where you are happy with it?

____

Are you interested in discussing your health with our naturopath?

____

When was the last time you refreshed your pillow?

____

The information supplied here today is correct to the best of my knowledge. I understand it is my responsibility to inform my Chiropractor of any changes to my condition or medication. I understand the payment of my account is required at the time of visit and I am responsible for the cost of my care.

SIGNATURE: ___________________________________ DATE: ____________________________

FOR OFFICE USE ONLY

Consent to Chiropractic Care

Chiropractic has been shown to be an effective treatment for neck pain, headaches and other similar conditions when compared to other modalities of treatment.

The risk of injury or complication from chiropractic care is lower than those associated with many other treatments and procedures given for the same symptoms.

The purpose of this document is to provide you with information necessary to consent chiropractic care including spinal manipulation.

Possible adverse outcomes following care:

- Temporary soreness and tenderness (sometimes)
- Fatigue, headache, dizziness or nausea (uncommon)
- Strain/Sprain or disc injury in the neck or lower back (rare)
- Rib fracture (very rare)
- Arterial Dissection (extremely rare)

Please note this is not an exhaustive list of all possible outcomes, if you have any specific concerns please raise these with your chiropractor.

SIGNATURE: ______________________________ DATE: ________________________________

Doctor's Examination Notes