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New Patient Application -- Pregnancy

At Keep Moving Chiropractic, we are committed to serve our patients in a professional clinical environment and to empower patients to actively participate in their healthcare. If you are accepted as a patient at Keep Moving Chiropractic we will give our expert recommendation to help achieve the most amount of improvement in the least amount of time.

SECTION 1:
Personal Data

Patient's Name: First_____MI_____Last_____

Prefers to be called_____Birthdate_____/_____/_____M ☐ F ☐

Parent or Guardian's Name if Patient is a Minor _____

Home Address _____

City_____State_____Zip_____

Home Ph# (___)_____Work Ph# (___)_____Cell Ph# (___)_____

Email Address_____Contact Preference: Home Ph# ☐ Work Ph# ☐ Cell Ph# ☐ Email ☐

Occupation_____Current Employer_____Contact Ph#(___)_____

Work Address_____City_____State_____Zip_____

Are you currently pregnant? ☐Yes ☐No ☐Maybe Have you ever been pregnant?☐Yes ☐No

Number of Children_____Ages_____

A copy of your insurance card[s] will be made, in addition, please complete the information requested below:

Insurance Information Are you the policy holder? ☐Yes ☐No If No, who is? Spouse☐ Parent☐ Employer☐

Policy Holder's First Name _____MI_____Last_____DOB:_____

Policy Holder's Social Security #:_____Policy Holder's Employer:_____

Do you have secondary insurance? Yes ☐ No☐ If yes, please complete the following:Same as above ☐

Policy Holder's First Name _____MI_____Last_____DOB:_____

Policy Holder's Social Security #:_____Policy Holder's Employer:_____

Referred By_____

Emergency Contact Person_____Phone# (___)_____

SECTION 2

Reason for Beginning Care-Pregnancy Adjustment / Webster Technique

What is the reason for your visit? _____

_____

Is this your first pregnancy? (Y / N) How many births have you had? _____

When is your due date? ___ /___ /___ How many weeks pregnant are you? _ _

Where are you planning to deliver? (circle one) · At Home · At a Birthing Center · At a Hospital

Position of baby: · Vertex (head down) · Transverse (sideways) · Breech (bottom/feet down) · Unknown

· Other: _____

Are you having any of the following symptoms with this pregnancy?

	Morning Sickness		Arm Pain/Leg Pain		Difficulty Sleeping
	Headaches		Swelling of Legs/Feet/Ankles		Back Pain
	Gestational Diabetes		Acid Reflux/Heartburn		Toxemia

Did you have any of the following difficulties with any previous pregnancies?

	Transverse		Induced Labor		C Section
	Breech		Epidural		Vacuum Extraction
	Brow/Facial		Episiotomy		Forceps

When was your last menstrual cycle? ___ /___ /___ Do you plan on breastfeeding? (Y / N)

Do you eat a special diet? (Y / N) _____

Is there anything you feel we should know about your previous pregnancy/pregnancies (if applicable)?

_____

_____

_____

_____

Are you in discomfort/pain? (Y / N) How severe is your pain? 1 2 3 4 5 6 7 8 9 10 (1 is mild, 10 severe)

What type of pain is it? · Aching · Sharp · Dull · Numb · Tingling · Shooting · Burning · N/A

Does your pain interfere with your daily life? (Y / N) If yes, how? _____

_____

_____

Is there any additional information you feel we should know about you?

_____

_____

_____

_____

Medications:

Please list all of the medications you are taking including over the counter, herbs & vitamins and nutritional supplements. If none please write: NONE

Name/Dose/Frequency

_____

_____

_____

_____

_____

Name/Dose/Frequency

_____

_____

_____

_____

_____

SECTION 3

Healthy Habits & Lifestyle

EXERCISE	**DIET**	**ALCOHOL/TOBACCO/RECREATIONAL DRUG USE?**
Do you exercise? ☐ Yes ☐No How often do you exercise? _____Days/week _____Hours/day Stretching/Flexibility ☐ Yes ☐ No Running/Walking ☐ Yes ☐ No Rowing/Swimming ☐ Yes ☐ No Competitive Athlete ☐ Yes ☐ No Pilates/Yoga ☐ Yes ☐ No Group Exercise ☐ Yes ☐ No Weight Lifting ☐ Yes ☐ No Other:_____ _____	Do you have a healthy diet? ☐ Yes ☐ No How many servings of fruits & vegetables per day? #_____ How many 8oz glass of water per day? #_____ Do you drink caffeinated beverages? ☐ Yes ☐ No How many per day? #_____ Do you have any food allergies? _____ _____ Have you ever had an eating disorder? ☐ Yes ☐ No	Do you use any of the above? ☐ Yes ☐ No How many cigarettes do you smoke? _____/day or _____/week Do you use smokeless tobacco? ☐ Yes ☐ No If Yes, How much do you use a day? Cans or pouches _____/day Do you have history of alcohol use? ☐Yes ☐No # drinks _____/day _____/wk (1 drink is equal to 12oz can of beer, 1.5oz liquor, 80 proof, 5 oz wine)
SLEEPING PATTERN	**DAILY STRESS LEVEL SCALE**	
Hours of sleep per night? ____hrs How is the quality of sleep? Excellent Good Fair Poor Sleep interrupted _____x/night	**Low** **HIGH** 0 1 2 3 4 5 6 7 8 9 10 Have you ever sought help for a mental health issue? ☐Yes ☐No	This space intentionally blank.