TOUCH OF LIFE CHIROPRACTIC
PREGNANCY CASE HISTORY

Dear Patient:
Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case.

Date: _____

Name: _____Home Phone _____Cell Phone _____

Home Address: _____Work Phone _ _____

Birthdate: _____ Marital Status: ___ Height: _____ Weight _____ Age _____

Place of Employment: _____Occupation: _____

Email: _____Spouse's Name: _____ # Children: _____

Whom may we thank for referring you to our office? _____

Have you ever been to a Chiropractor before? ____ D.C.'s Name: _____

Who is your Midwife or OB/GYN? _____ Phone#:_____

The reason for this visit is a result of __Breech Presentation __backache of pregnancy __headache

__trauma __chronic condition __other Explain: _____

How many pregnancies have you had? ___ Vaginal Delivery _____ Cesarean Section _____

Please explain any complications with this or past pregnancies _____
_____

Are you taking any medications and/or vitamins? _____ If yes, please explain _____
_____

What accidents have you had?_____

What surgeries have you had? _____

Do You…..
Smoke __no __yes 1-2-3-4 packs/day Drink coffee __no __yes 1-2-3-4 cups/day

Drink Tea __no __yes 1-2-3-4 cups/day Drink Diet soda __no __yes 1-2-3-4 cups/day

Exercise regularly __no __yes Eat a balanced diet __no __yes Sleep 8 hours a day __no __yes

HAVE YOU EVER SUFFERED FROM….

Dizziness	__before pregnancy	__during pregnancy
Backaches	__before pregnancy	__during pregnancy
Water Retention	__before pregnancy	__during pregnancy
Diabetes	__before pregnancy	__during pregnancy
High Blood Pressure	__before pregnancy	__during pregnancy
Headaches	__before pregnancy	__during pregnancy
Asthma	__before pregnancy	__during pregnancy
Stomach Trouble	__before pregnancy	__during pregnancy
Nervousness	__before pregnancy	__during pregnancy
Sinus Trouble	__before pregnancy	__during pregnancy
Neck Pain	__before pregnancy	__during pregnancy
Other	_____	

How many weeks gestation is your baby? _____ When is your due date? _____

INSURANCE INFO:

Insurance Co. Name: _____ Address: _____

Phone#: _____Group # _____ Policy or contract # _____

Plan Name: _____ Insured's Name: _____

Relation: _____ Birthdate: _____ Insured's SS# _____

Insured's Employer _____

NOTES:

_____
_____
_____
_____
_____
_____
_____

Patient Signature: _____

It is our new patient policy that any charges for today will be discussed with you prior to services being rendered. Payment is due upon completion of services today. If your insurance contributes to your care, any insurance payment will be reimbursed to you or credited to your account. If you have any questions, please ask for assistance. Thank you.