Miceli Family CHIROPRACTIC

CONFIDENTIAL PATIENT HEALTH PROFILE FOR THE PREGNANT PATIENT

Today's Date: _____

Your answers will help us determine if our care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case but will work to refer you to the appropriate health care provider. If you need help with this form, please do not hesitate to ask.

PERSONAL INFORMATION

Name: Mrs. Ms Miss Dr. _____
Marital Status: M S W D **Alberta Health Care Number:** _____
Address: _____ **City:** _____
Postal Code: _____ **Home #:** _____ **Cell/Business #**_____
Date of Birth: dd_____mm_____yy_____ **Age:** _____
Email address (for appointment reminders): _____
Employer: _____ **Occupation:** _____
Is this a WCB related injury: Yes___ No___
Hobbies (what occupies your spare time?)_____
Emergency Contact: _____**Children (#)** _____
How did you hear about our office or whom may we thank for referring you?
_____

PREGNANCY INFORMATION

How many weeks pregnant are you? _____ **When is your Due Date?** _____
Where is your birth to take place? ☐ Home ☐ Birthing Centre ☐ Hospital
Any expected or current complications? (Breech presentation, placenta previa, gestational diabetes, previous c-sections, hypertension etc.) _____
_____
Do you have Birth Support? ☐ Midwife ☐ Douala ☐ neither
Do you have a Birth Plan in place? ☐ Yes ☐ No **If No, why not?**_____
Are you involved in any Pre-natal Classes? (Bradley Method, HypnoBirthing, Birthing Within, CHR)
_____
Are you taking part in any pre-natal fitness programs? _____
Do you know the sex of the baby? _____ **Do you plan to Breast Feed?** ☐ Yes ☐ No

HEALTH INFORMATION

What is your major complaint?
_____
How long have you had this condition?
_____
Have you had this or similar conditions in the past? ☐No ☐ Yes, **When?**
_____
What activities aggravate your condition?
_____

What makes it better?

_____

Does the pain refer anywhere (leg, buttock, chest etc.)? _____
Is this condition getting progressively worse? ☐ Yes ☐ No ☐Constant ☐ Intermittent
If you are experiencing pain, how would you describe it? (Dull, sharp, shooting etc.)

_____

Is this condition interfering with your ☐ Work ☐ Sleep ☐ Daily Routine ☐Other_____
On a scale of 1 to 10, rate your stress levels. (0 = none, 10 = extreme)
Occupational _____ **Personal** _____
How long has it been since you really felt well? _____
Has there been a medical diagnosis of your complaint? ☐ Yes ☐ No **If "yes", list the Doctor's name and the diagnosis:** _____

Please check all that apply to your current/past medical history:

____ Neck Pain/Stiffness
____ Mid Back Pains
____ Low Back Pain
____ Pins/Needles in Arms
____ Numbness in Fingers
____ Pins/Needles in Legs
____ Numbness Legs/Toes
____ Headaches
____ Fatigue
____ Weakness
____ Insomnia
____ Fever
____ Chills
____ Weight Change
____ Skin Rashes
____ Bruise Easily
____ Dizziness
____ Fainting
____ Seizures
____ Vision Trouble
____ Nose Bleeds
____ Sinus Problems
____ Ringing in Ears
____ Hearing Trouble
____ Chronic Sore Throats
____ Difficulty Breathing
____ Asthma
____ Allergies
____High Blood Pressure
____High Cholesterol
____ Chest Pain
____ Heart Palpitations
____ Heart Murmur
____ Heart Burn/Acid Reflux
____ Varicosities
____ Swollen Extremities
____ Lumps in Breast
____ Breast Discharge
____ Abdominal Pain
____ Decreased Appetite
____ Increased Appetite
____ Excess Gas
____ Vomiting
____ Diarrhea/ Constipation
____ Hemorrhoids
____ Painful urination
____ Frequent Urination
____ Bedwetting
____ Prostate Problems
____ Impotence
____ Sterility
____ Miscarriage
____ Painful Menstruation
____ Irregular Periods
____ Menopause
____ Anxiety
____ Depression
____ Memory Loss
____ Other…

List surgeries, broken bones, and major illnesses (including childhood): _____

_____

_____

Have you ever been hospitalized? ☐ Yes ☐ No **Reason:** _____
How healthy is your family? Are there any conditions like diabetes, cancer or heart disease on your mother or father's side? If so explain: _____

_____

Have you ever been in an auto accident?
☐ Never ☐ Past Year ☐ Past 5 Years ☐ Over 5 Years
Is there or might there be a lawyer involved? ☐ Yes ☐ No
Description of accident:

_____

_____

_____

Is your insurance company involved? ☐ Yes ☐ No

LIFESTYLE HABITS

Do you smoke: ☐Yes ☐ No **How much?** _____
Alcohol Consumption? ☐ Yes ☐ No **How many drinks per week?** _____
Are you a coffee drinker? ☐ Yes ☐ No **How many cups a day?** _____
Are you a soda drinker? ☐ Yes ☐ No **How many cans a day?** _____
How many glasses of water do you drink per day? ☐ 0-4 ☐ 4-8 ☐ 8-12 ☐12+
Do you sleep well? Rate your sleep from 1 – 10 _____ (10 being the best sleep possible)
How many hours on average do you get in a night? ☐ 4-6 ☐ 6-8 ☐ 8-10 ☐ 12+
How do you sleep? ☐ Stomach ☐ Side ☐ Back **How old is your current bed?** _____
Do you eat a healthy diet? ☐ Yes ☐ No
Have you ever been to a chiropractor before? ☐ Yes ☐ No
List any prescription drugs, over the counter medications, vitamins, and natural supplements you are taking: _____
_____
Medical Doctor's Name/Location _____
When was your last visit? _____**Reason?** _____
Have you consulted other healthcare providers for this condition? (RMT's, Physio, Acupuncture, MD, ND etc): _____
_____

Please draw the location of your pain or discomfort on the images below. Use the symbols to represent the type(s) of pain:

D = Dull	**S = Sharp / Stabbing**	**A = Annoyance**
B = Burning	**T = Tingling (Pins and Needles)**	**G= Grinding**
N = Numb	**C = Cramping**