Anchor Family Chiropractic

Pregnancy Intake Form

Patient Information

First Name _____ Last Name _____

Street Address _____

Town/City _____ State _____ Zipcode _____

Home Phone _____ Cell _____

Email _____

Birth Date _____ Age _____ Sex _____

Height _____ Weight _____

How did you hear about our office? _____

Were you referred to this office? YES NO

If, yes by whom? _____

Who is your primary care physician? _____

Date and reason for last doctor visit? _____

Are you also receiving care from any other health professionals? __ Yes __ No

If yes, please name them _____

Current Health Conditions

What health condition(s) bring you into our office?

1. _____
2. _____
3. _____
4. _____
5. _____

Have you received care for these problems before? __ Yes __ No

Health Goals

Your top three health goals.

1. _____
2. _____
3. _____

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Chiropractic History

What would you like to gain from chiropractic care?

__ Resolve existing condition(s) __ Overall wellness __ Both

Have you ever seen a chiropractor? __ Yes __ No

If so, who and when? _____

What is their specialty? __ Pain relief __ Physical Therapy & Rehab __ Nutrition __ Other

Do you have any health concerns for other family members today?

Traumas: Physical Injury History

Have you ever had any significant falls, surgeries or other injuries as an adult? __ Yes __ No

If yes, please explain _____

Notable childhood injuries? __ Yes __ No If yes, explain: _____

Youth or college sports? __ Yes __ No If yes, list injuries: _____

Any auto accidents? __ Yes __ No If yes, explain: _____

Exercise frequency: __ None __ 1-2x/week __ 3-5x/week __ Daily

What types of exercise? _____

How do you sleep? __ Back __ Side __ Stomach

Do you wake up? __ Refreshed and ready __ Stiff and tired

Do you commute to work? __ Yes __ No If yes, how many minutes per day?

_____

List any problems with flexibility (putting socks/shocks on, etc.) _____

_____

How many hours per day do you typically spend sitting at a desk on a computer, tablet, phone?

_____

Toxins: Chemical & Environmental Exposure

Please circle/rate your CONSUMPTION of each: (1=None, 3=Moderate, 5=High)

Alcohol	1	2	3	4	5	Processed Foods	1	2	3	4	5
Water	1	2	3	4	5	Artificial Sweeteners	1	2	3	4	5
Sugar	1	2	3	4	5	Sugary Drinks	1	2	3	4	5
Dairy	1	2	3	4	5	Cigarettes	1	2	3	4	5
Gluten	1	2	3	4	5	Recreational Drugs	1	2	3	4	5

Please list any drugs/medications/vitamins/herbs/others that you are taking and why:

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Thoughts: Emotional Stress & Challenges

Please rate your STRESS for each: (1=None, 3=Moderate, 5=High)

Home	1	2	3	4	5	Money	1	2	3	4	5
Work	1	2	3	4	5	Health	1	2	3	4	5
Life	1	2	3	4	5	Family	1	2	3	4	5

Previous Birth Experience

Is this your first pregnancy? __ Yes __ No

- If not, please tell us about your previous pregnancy and/or birth experience(s).

Do you plan to follow the same plan as your previous delivery? __ Yes __ No

- If no, what would you like to change?

Conception & Early Pregnancy

When is your expected or calculated due date? _____

Did you have any difficulty conceiving? __ Yes __ No

- If yes, please explain:

Have you ever used any form of hormonal or oral contraceptives? __ Yes __ No

- If yes, which ones, and for how long? _____

When was your last menstrual cycle? _____

What was your pre-pregnancy weight? _____ lbs. Current weight? _____ lbs.

Have you experienced morning sickness? __ Yes __ No

- If yes, please explain:

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Current Health Conditions

What type of exercise(s) are you currently performing?

Please tell us about your current diet, and any dietary restrictions: _____

_____

Have you taken any medications or supplements during your pregnancy? __ Yes __ No

- If yes, please explain:

Have you had any slips, falls, or other physical traumas during the pregnancy? __ Yes __ No

- If yes, please explain:

Have you had any major emotional stressors during your pregnancy? __ Yes __ No

- If yes, please explain:

Your Birth Plan

Please list your top three goals for this pregnancy:

1. _____
2. _____
3. _____

Do you currently have a birth plan? __ Yes __ No

- If yes, please explain:

Are you taking any pre-natal or birthing classes? __ Yes __ No

- If yes, please explain:

Who is your OB/GYN or midwife? _____

- Will they be present for delivery? __ Yes __ No

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Who is your birth provider? _____

Do you intend to have a doula or birth coach present? __ Yes __ No

- If yes, please explain:

Do you wish to have a natural vaginal labor and delivery? __ Yes __ No

- If not, what concerns do you have?

Your Post-Birth Plan

Do you plan on breastfeeding your child? __ Yes __ No

What do you intend to do for vaccines?

Is there anything else you'd like to tell us about your pregnancy or birth plan?

What would you like to gain from chiropractic care during your pregnancy?

Are there any burning questions you want to be sure to ask today?

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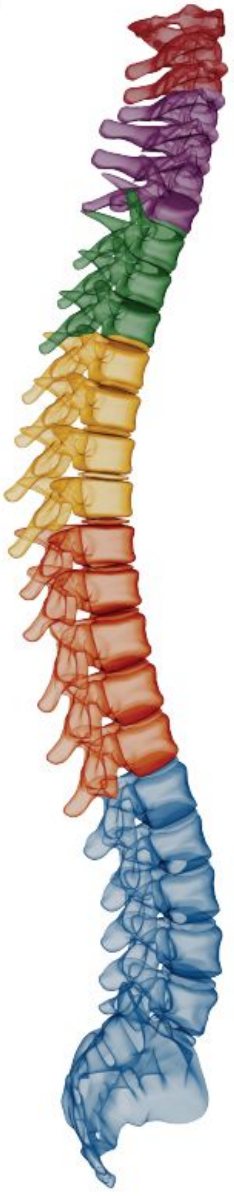

REGIONS	FUNCTIONS	SYMPTOMS	
		PAST / PRESENT	PAST / PRESENT
Cervical	• Autonomic Nervous System • ENT System • Vision, Balance & Coordination • Speech • Immune System • Digestive System • Nerve Supply to Shoulders, Arms & Hands • Sympathetic Nucleus • Metabolism	☐☐ Colic & Excessive Crying ☐☐ Ear & Sinus Infections ☐☐ Allergies & Congestion ☐☐ Immune Deficiency ☐☐ Headaches & Migraines ☐☐ Vertigo & Dizziness ☐☐ Sore Throat & Strep ☐☐ Swollen Tonsils & Adenoids ☐☐ Vision & Hearing Issues ☐☐ Low Energy & Fatigue ☐☐ Difficulty Sleeping ☐☐ Pain, Numbness & Tingling in Arms to Hands	☐☐ Epilepsy & Seizures ☐☐ Sensory & Spectrum ☐☐ ADD / ADHD ☐☐ Focus & Memory Issues ☐☐ Anxiety & Stress ☐☐ Balance & Coordination ☐☐ Speech Issues ☐☐ TMJ / Jaw Pain ☐☐ Stiff Neck & Shoulders ☐☐ Depression ☐☐ High Blood Pressure ☐☐ Poor Metabolism & Weight Control
Upper Thoracic	• Upper G.I. • Respiratory System • Cardiac Function	☐☐ Reflux / GERD ☐☐ Chronic Colds & Cough ☐☐ Asthma	☐☐ Bronchitis & Pneumonia ☐☐ Functional Heart Conditions
Mid Thoracic	• Major Digestive Center • Detox & Immunity	☐☐ Gallbladder Pain / Issues ☐☐ Jaundice ☐☐ Fever	☐☐ Indigestion & Heartburn ☐☐ Stomach Pains & Ulcers ☐☐ Blood Sugar Problems
Lower Thoracic	• Stress Response • Filtration & Elimination • Gut & Digestion • Hormonal Control	☐☐ Behavior Issues ☐☐ Hyperactivity ☐☐ Chronic Fatigue ☐☐ Chronic Stress	☐☐ Allergies & Eczema ☐☐ Skin Conditions / Rash ☐☐ Kidney Problems ☐☐ Gas Pain & Bloating
Lumbar, Sacrum & Pelvis	• Lower G.I. (Absorption & Motility) • Gut-Immune System • Major Hormonal Control	☐☐ Constipation ☐☐ Chrohn's, Colitis & IBS ☐☐ Diarrhea ☐☐ Bed-wetting ☐☐ Bladder & Urination Issues ☐☐ Cramps & Menstrual Issues ☐☐ Cysts & Endometriosis ☐☐ Infertility ☐☐ Impotency ☐☐ Hemorrhoids	☐☐ Sciatica & Radiating Pain ☐☐ Lumbopelvic / SI Joint Pain ☐☐ Hamstring Tightness ☐☐ Disc Degeneration ☐☐ Leg Weakness & Cramps ☐☐ Poor Circulation & Cold Feet ☐☐ Knee, Ankle & Foot Pain ☐☐ Weak Ankles & Arches ☐☐ Lower Back Pain ☐☐ Gluten & Casein Intolerance

Dr. Claire Boehmer | Anchor Family Chiropractic

733 SE Alices Rd, Waukee IA | 515-987-7871