Health From Within
Chiropractic • Nutrition • Fitness • Family

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Pregnancy
Wellness Profile and Application for Care

Practice Member Information _____ File _____

Name: _____
Appointment Date: Month _____ Day ____ Year _____ Birth Date: Month _____ Day ____ Year _____
Home Address: _____
Home Phone: _____ May we leave a message? ☐ Yes ☐ No
Cell Phone: _____ May we leave a message? ☐ Yes ☐ No
Work Phone: _____ May we leave a message? ☐ Yes ☐ No
Email: _____
May we add you to our email newsletter and calendar of events? ☐ Yes ☐ No (Your email will not be shared)
Spouse's name? _____
Name(s) and age(s) of children: _____ _____ _____ _____
Occupation: _____
Do you primarily: ☐ Sit ☐ Stand ☐ Perform repetitive tasks
How did you hear about us? _____

Healthcare History

Have you had previous chiropractic care? ☐ No ☐ Yes
Who was your previous Chiropractor? _____
Where? _____ When? _____
Were X-rays taken in the last 6 months? ☐ Yes ☐ No
What was the primary reason for consulting that office?
☐ Relief Care - Symptom relief of pain or discomfort
☐ Corrective Care - Correcting, relieving and stabilizing spinal, joint and postural issues
☐ Wellness Care - Maximizing the body's ability for optimal healing and function
Do you feel your previous chiropractic care was effective? ☐ No ☐ Yes
Please explain: _____
Are you wearing: ☐ Heel Lifts ☐ Custom Orthotics
Family Doctor: _____
Date and reason of last visit: _____
May we contact your family doctor regarding your care at our office if necessary? ☐ No ☐ Yes
Naturopathic Doctor: _____
Date and reason of last visit: _____

Other Specialists and healthcare professionals:
Name: _____
Professional Designation: _____
Date and reason of last visit: _____
Name: _____
Professional Designation: _____
Date and reason of last visit: _____

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Pregnancy Profile

How far along in your pregnancy are you?_____ When is your baby's due date? Month _____ Day ____ Year _____
Have you taken any medications during this pregnancy? ☐ No ☐ Yes:
OTC and Reason: _____
Prescription and Reason: _____
Vaccines and Reason: _____
Have you experienced any physical trauma during this pregnancy? ☐ No ☐ Yes _____
Have you had any evaluation procedures (ultrasound, amniocentesis, chorionic villus sampling)? ☐ No ☐ Yes
Dates and Reasons: _____
_____
_____
Have there been any stressful events in your life during this pregnancy? ☐ No ☐ Yes _____
_____
_____
What type of birth care provider are you planning on using? ☐ Midwife ☐ OB/Gyn ☐ Medical Doctor ☐ Other
Where do you plan on delivering? _____
Is this your first pregnancy? ☐ Yes ☐ No:
If not, how many pregnancies previously? _____
How many children do you have? _____
Miscarriages? ☐ No ☐ Yes: ☐ D&C ☐ Natural Miscarriage
How many vaginal deliveries? _____
How many caesarean sections? _____
Have there been any complications during your previous deliveries? ☐ No ☐ Yes _____
Was labor induced/use of Pitocin? ☐ No ☐ Yes ☐ Unknown
Did your care provider rupture your membranes? ☐ No ☐ Yes ☐ Unknown
Was there any back or hip pain during labor? ☐ No ☐ Yes
Was baby in a suboptimal position during the pushing phase of any labor? ☐ No ☐ Yes ☐ Unknown
Did you receive an epidural? ☐ No ☐ Yes
Were there any operative devices used? ☐ No ☐ Yes ☐ Forceps ☐ Vacuum
Any postpartum complications or long term consequences? ☐ No ☐ Yes _____
_____

Have you experienced any of the following symptoms during this pregnancy or a previous pregnancy?

CURRENT	PREVIOUS		CURRENT	PREVIOUS	
☐	☐	Headaches	☐	☐	Carpal Tunnel (numbness in hands/fingers)
☐	☐	Facial Paralysis	☐	☐	Low/Mid Back Pain
☐	☐	Chronic Fatigue	☐	☐	Breech or Sidelying Presentation
☐	☐	Nausea/"Morning Sickness"	☐	☐	Round Ligament Pain/Pulling (front of belly)
☐	☐	Heartburn/Indigestion	☐	☐	Pain in your Pubic Bone
☐	☐	Preeclampsia	☐	☐	Pins/Needles in the Front/Side of your Leg
☐	☐	Gestational Diabetes	☐	☐	Pain in Posterior Leg (Sciatica)
☐	☐	Constipation	☐	☐	Leg Cramps
☐	☐	Hemorrhoids	☐	☐	Swelling of Ankles, Legs and Feet

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Wellness Profile

Do you have a specific concern that brings you in?

☐ No, I'm interested in having my nervous system assessed to achieve optimal health and functioning.

☐ Yes: _____

If yes, please answer the following questions:

What is your primary area of complaint today? _____

Was there a specific injury or event that brought this primary complaint on? _____

Do you have any additional complaints besides your primary complaint? Second _____ Third _____

On a scale of 1-10 with 10 being the worst pain and zero being no pain, rate your primary and other complaints:

1st: ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10 **2nd:** ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10 **3rd:** ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10

How long have you been aware of this? _____ days_____ weeks _____ months years

Where else does this pain go in your body? _____

How often do you experience this? ☐ daily ☐ weekly ☐ monthly ☐ comes and goes ☐ constantly

How would you describe the pain/discomfort?

☐ Dull ☐ Achy ☐ Throbbing ☐ Stabbing ☐ Tight/Stiff ☐ Burning ☐ Sharp ☐ Other _____

Do you notice any other problems in your body when you get this pain/discomfort?_____

Do you feel your condition getting progressively worse? ☐ No ☐ Yes

Do you feel your condition can heal? ☐ No ☐ Yes

What have you tried that ***has*** helped? ☐ Ice ☐ Heat ☐ Medication ☐ Massage ☐ Physical Therapy ☐ Chiropractic ☐ Other _____

What have you tried that ***hasn't*** helped? ☐ Ice ☐ Heat ☐ Medication ☐ Massage ☐ Physical Therapy ☐ Chiropractic ☐ Other _____

See additional ***Spinal Nerve Function Form*** to provide further detail on your *Wellness Profile* (***Page5***)

Lifestyle Information

The human body is designed to be healthy. The primary system in the body which coordinates health and function is the nervous system. Your nervous system is surrounded and protected by the bones of the spine, called vertebrae. Physical, emotional, and chemical stresses, common to our contemporary lifestyle, can result in misalignment to the spinal column as well as damage the delicate nervous system. The result is a condition called a ***Vertebral Subluxation.*** The remainder of the intake form addresses the possible factors which may contribute to vertebral subluxation in your spine which may be impeding your body's ability to heal.

Physical

Height _____ Weight _____

Are you happy with your current physical appearance, body weight, and abilities? ☐ Yes ☐ No

If 'No', what would specifically make you happy about this area of your health? _____

Frequency of exercise/week: Cardio? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

Resistance training? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

Do you stretch after exercise or after other activities of poor posture? ☐ Yes ☐ Sometimes ☐ No

Hours of sleep/night? ☐ >6 ☐ 7-9 ☐ 10+

Do you feel refreshed upon waking? ☐ Always ☐ Sometimes ☐ Rarely

Age of mattress? _____ Do you feel your mattress is appropriate for your sleeping style? ☐ No ☐ Yes

Which position do you sleep? ☐ Back ☐ Belly Side: ☐ Right ☐ Left ☐ Both

Number of hours spent commuting/week? ☐ 0-2 ☐ 3-5 ☐ 6-8 ☐ 9-11 ☐ 12+

Number of hours spent at a desk or computer/week? ☐ 0 ☐ 1-5 ☐ 6-10 ☐ 11-20 ☐ 21-40 ☐ 41+

Number of hours spent on smart device/tablet/week? ☐ 0 ☐ 1-5 ☐ 6-10 ☐ 11-20 ☐ 21-40 ☐ 41+

Do you perform any repetitive tasks at home or at work? ☐ No ☐ Yes

Have you ever been hospitalized or had surgery? ☐ No ☐ Yes If yes why and when? _____

_____

Have you ever been in a motor vehicle accident (even if it was minor)? ☐ No ☐ Yes

If yes, what kind and when? _____

Were you evaluated and treated after each accident? ☐ No ☐ Yes

Have you had any non-vehicle accidents or falls? ☐ No ☐ Yes _____

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Early Years

To your knowledge, was your birth process difficult and/or did it involve any interventions? ☐ No ☐ Yes
☐ If yes: ☐ Forceps ☐ Vacuum ☐ Caesarean ☐ Breech ☐ Other _____
Were you breast fed? ☐ No ☐ Yes For how long? _____
Did you experience emotional trauma as a child? ☐ No ☐ Yes _____
How many times were you given antibiotics as a child that you remember? ☐ 0 ☐ 1-3 ☐ 5+
Did you ever have ear infections as a child? ☐ No ☐ Yes _____
Any major childhood illness? ☐ No ☐ Yes _____

Emotional

Rate your current level of ***personal stress*** in your life: . . . . . ☐ None ☐ Low ☐ Moderate ☐ High
Rate your current level of ***relationship stress*** in your life: . . . . . ☐ None ☐ Low ☐ Moderate ☐ High
Rate your current level of ***financial stress*** in your life: . . . . . ☐ None ☐ Low ☐ Moderate ☐ High
Rate your current level of ***health stress*** in your life: . . . . . ☐ None ☐ Low ☐ Moderate ☐ High
Rate your current level of ***family stress*** in your life: . . . . . ☐ None ☐ Low ☐ Moderate ☐ High
Rate your current level of ***career stress*** in your life: . . . . . ☐ None ☐ Low ☐ Moderate ☐ High
Do you feel you have a supportive network of friends and family? . . . ☐ Yes ☐ No
Do you feel you have healthy coping strategies for life stress? . . . . . ☐ Yes ☐ No
Do you feel your spiritual health is strong? . . . . . ☐ Yes ☐ No

Chemical

Were you vaccinated as a child? . . . . . ☐ No ☐ Yes
Any adverse reactions to vaccines? . . . . . ☐ No ☐ Yes _____
Do you choose to have annual flu shots? . . . . . ☐ No ☐ Yes
Do you take antibiotics? . . . . . ☐ No ☐ Yes, How often? _____
How many glasses of water/day: . . . . . ☐ 0 ☐ 1-3 ☐ 4-6 ☐ 7-9 ☐ 10+
How many glasses of caffeinated beverages/day: . . . . . ☐ 0 ☐ 1-3 ☐ 4-6 ☐ 7-9 ☐ 10+
How many glasses of cow's milk, juice and pop/day: . . . . . ☐ 0 ☐ 1-3 ☐ 4-6 ☐ 7-9 ☐ 10+
Do you eat gluten? . . . . . ☐ No ☐ Yes ☐ Trying to eliminate from diet
Do you eat dairy? . . . . . ☐ No ☐ Yes ☐ Trying to eliminate from diet
Do you eat refined sugars? (white sugar, white bread and pasta) . . . . . ☐ No ☐ Yes ☐ Trying to eliminate from diet
Do you eat boxed/frozen foods? . . . . . ☐ No ☐ Yes ☐ Trying to eliminate from diet
Do you choose organic foods? . . . . . ☐ No ☐ Yes, which: ☐ Veggies ☐ Fruits ☐ Meats ☐ Grains ☐ All
Do you eat any artificial sweeteners? (Splenda, Aspartame, Diet Soda, etc) . ☐ No ☐ Yes
Any food/drink allergies, sensitivities, intolerances? . . . . . ☐ No ☐ Yes _____
Do you smoke? . . . . . ☐ No ☐ Yes ☐ I used to for__ years ☐ I wish I didn't
Are you or have you been exposed to second hand smoke? . . . . ☐ No ☐ Yes
Do you drink alcohol? . . . . . ☐ No ☐ Yes ☐ 0-6/week ☐ 6-12/week ☐ 12+/week
Do you take a probiotic daily? . . . . . ☐ No ☐ Yes, _____ CFU's/day
Do you take vitamin D3 daily? . . . . . ☐ No ☐ Yes, _____ IU's/day
Do you take Omega 3 Fish Oils daily? . . . . . ☐ No ☐ Yes, _____ mg/day ☐ Capsule ☐ Liquid
Other supplements or homeopathics? _____
Any other daily medication and their purpose? _____
_____
Do you and your medical doctor have a plan in place to reduce &/or eliminate any long term medications? ☐ No ☐ Yes

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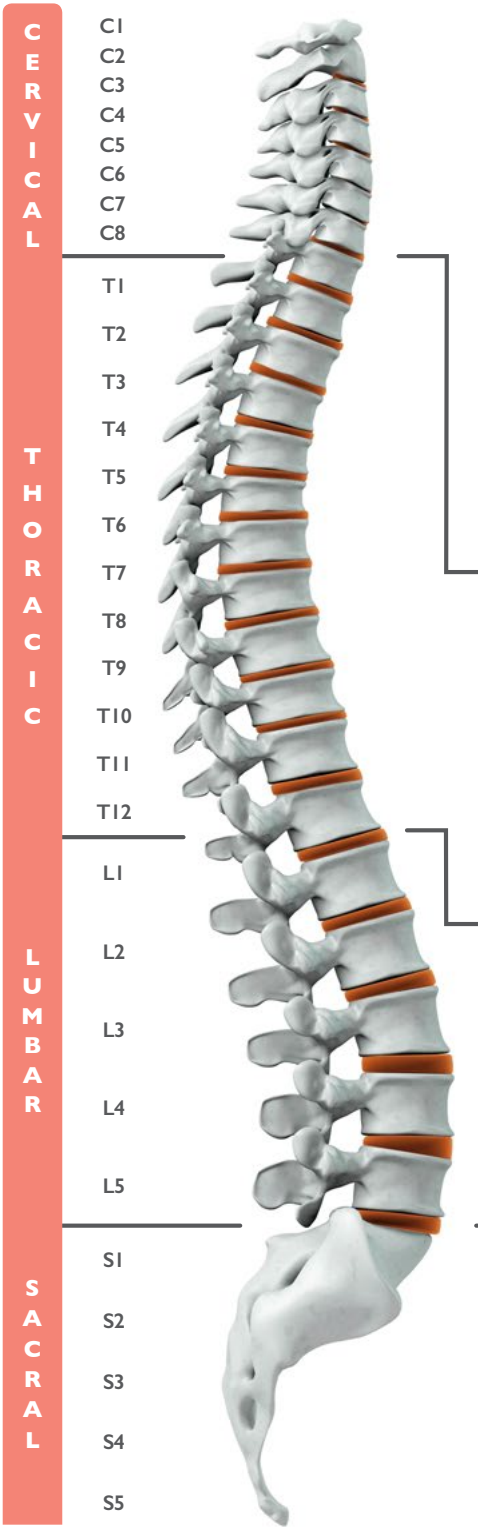
SPINAL NERVE



ORGANS & GLANDS

The organs and glands listed below are linked to the corresponding sections of the spine and it's spinal nerves.

ASSOCIATED SYMPTOMS

Please indicate below any symptoms you are currently experiencing as well as any you have previously experienced.

ORGANS & GLANDS	CURRENT	PREVIOUS	CURRENT	PREVIOUS
Parotid Gland • Scalp Base of Skull • Eyes Lacrimal Gland • Sinuses Inner, Middle & Outer Ear Nose • Mouth Intracranial Blood Vessels Sympathetic Nervous System Neck Muscles • Diaphragm Shoulders • Elbows • Arms Wrists • Hands & Fingers Tonsils • Vocal Cords Esophagus • Heart Lungs • Chest • Thyroid	☐	☐ Sinus & Ear Pain/Infection ☐ Runny Nose & Allergies ☐ Frequent Head Colds ☐ Sore Throat & Tonsilitis ☐ Strep Throat ☐ Chronic Cough & Croup ☐ Difficulty Breathing ☐ Poor Immunity ☐ Dizziness & Vertigo ☐ Tinnitus & Ear Fullness ☐ Vision Problems ☐ Watery/Dry Eyes ☐ Chronic Fatigue ☐ Poor Concentration ☐ Depression	☐	☐ Anxiety & Stress ☐ Seizures ☐ ADD/ADHD ☐ Thyroid Dysfunction ☐ Metabolic Dysfunction ☐ Insomnia ☐ High/Low Blood Pressure ☐ Enlarged Lymph Glands ☐ Migraines & Headache ☐ TMJ Pain ☐ Stiff Neck ☐ Arm Pain ☐ Hand/Finger Numbness ☐ Loss of Grip Strength
Arms • Wrists Esophagus • Chest • Heart Lungs • Trachea • Larynx Diaphragm • Stomach Gallbladder • Liver Pancreas • Small Intestine Spleen • Kidneys • Appendix Adrenals • Colon • Buttocks Uterus • Ovaries • Testes	☐	☐ Asthma ☐ Bronchitis & Pneumonia ☐ Congestion ☐ Reflux & GERD ☐ Indigestion & Heartburn ☐ Stomach Pains ☐ Ulcers ☐ Gas & Bloating ☐ Jaundice ☐ Liver Conditions ☐ Blood Sugar Dysregulation	☐	☐ Kidney Stones ☐ Gall Bladder Attacks ☐ Skin Conditions & Rashes ☐ Menstrual Cramps/PMS ☐ Infertility ☐ Menstrual Dysfunction ☐ Rashes & Eczema ☐ Hyperactivity ☐ Shoulder Pain ☐ Midback Pain ☐ Rib Pain
Large Intestine • Colon Thighs • Buttocks • Groin Knees • Legs • Feet Reproductive Organs	☐	☐ Irritable Bowel, Colitis, Crohn's ☐ Gas Pain & Constipation ☐ Diarrhea ☐ Hemorrhoids ☐ Bladder Infections ☐ Bladder Incontinence & Bedwetting ☐ Painful/Excessive Urination	☐	☐ Prostate Dysfunction & Impotence ☐ Ovarian Cysts & Endometriosis ☐ Fertility Problems/ Loss of Menstruation ☐ Low Back Pain ☐ Hip Pain ☐ Thigh Pain ☐ Numbness & Tingles in Legs
Buttocks • Groin • Legs Ankles • Feet • Toes Prostate Gland • Bladder Reproductive Organs	☐	☐ Varicose Veins ☐ Leg Cramping ☐ Restless Legs ☐ Poor Circulation & Cold Feet	☐	☐ Sciatica ☐ Pelvic Pain ☐ Knee Pain ☐ Ankle Pain & Sprains ☐ Foot Pain & Weak Arches

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Daily Activities: Effects of Current Conditions On Performance

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

Bending	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Concentrating	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Doing Computer Work	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Gardening	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Playing Sports	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Recreation Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Shoveling	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sleeping	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Watching TV	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Carrying	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Dancing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Lifting	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Pushing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Rolling Over	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Working	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Climbing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Doing Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sexual Activity	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Reading	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Running	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting to Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform

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Family Health

At our clinic we are not only interested in your health and wellness, but also the health and wellness of the important people in your life. Please mention below any health conditions or concerns you may have about your:

Children: _____

Spouse: _____

Mother: _____

Father: _____

Brothers/Sisters: _____

Are you seeking chiropractic care today for:

- ☐ Relief Care - Symptom relief of pain or discomfort
- ☐ Corrective Care - Correcting, relieving and stabilizing spinal, joint and postural issues
- ☐ Wellness Care - Maximizing the body's ability for optimal healing and function
- ☐ Pregancy Care: regular care throughout pregnancy to optimize the growth and development of my baby and prepare my body for a healthy delivery and fast recovery.

Do you have other concerns we should know about? _____

_____

_____

_____

_____

_____

_____

_____

_____

Goals & Consent

It's important for our doctor to know your goals in order to help you achieve them. What are your top health goals?

Short term (6-12 months): _____

Medium term (1-5 years): _____

Long term (5+ years): _____

I hereby authorize payment to be made directly to HEALTH FROM WITHIN for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to HEALTH FROM WITHIN for any and all services I receive at this office.

Consent to Evaluation

By checking the box and initialing below, I am acknowledging that I am NOT pregnant at the time of this examination, as I am aware of the risks of ionizing radiation to an unborn baby. ☐ _____

_____ _____

Consenting Adult's Signature Date

_____ _____

Doctor's Signature Date Form Reviewed

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