stamford balance
chiropractic studio

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CONFIDENTIAL HEALTH INFORMATION
Prenatal Intake Form

Section 1: Personal Information

First Name: _____ Last Name: _____ M.I. _____

Prefers to be called: _____ Birth Date: _____ /_____ / _____

Height: _____ Weight: _____ Age: _____ ☐ Male ☐ Female

Parent or guardian's name if patient is a minor: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Cell Phone: (_____) _____ Email Address: _____

Preferred method of contact: ☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ E-mail

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other Spouse's Name: _____

Number of children: ____ Children's Names and Ages: _____

Occupation/Job Description: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: (_____) _____

How did you hear about us? _____

Section 2: Current Pregnancy

Due Date/Week: _____ I am in my: _____ week of pregnancy.

Pre-pregnancy weight: _____ Current weight: _____ Height: _____

Childbirth preparation: ☐ Bradley ☐ LaMaze ☐ Other_____

Childbirth caregiver(s): ☐ OB/GYN ☐ Doula ☐ Midwife ☐ Other_____

Caregiver's name: _____

Caregiver's Phone #: (_____) _____ Last Visit to Caregiver: _____ /_____ / _____

I plan on giving birth at: ☐ Hospital ☐ Home ☐ Birth Center

Name of Hospital or Birth Center _____

What sleeping position do you prefer? ☐ Side ☐ Back ☐ Stomach

Any traumas during this pregnancy? ☐ Yes ☐ No

If yes, please describe: _____

_____

Any hospitalizations during this pregnancy? ☐ Yes ☐ No

If yes, please describe: _____

_____

Please list any medications or supplements you have been taking during this pregnancy. _____

_____H

ave you undergone any fertility treatment? If yes, Please describe: _____

_____

Section 3: Reasons for Seeking Care

I am seeking care at this office:

☐ Because of pain or symptoms during my pregnancy (Please complete section 3A)

☐ General wellness care during my pregnancy

☐ To help facilitate a more natural birth experience

☐ Breech or other malposition

☐ Other: _____

Section 3A: Your Symptoms

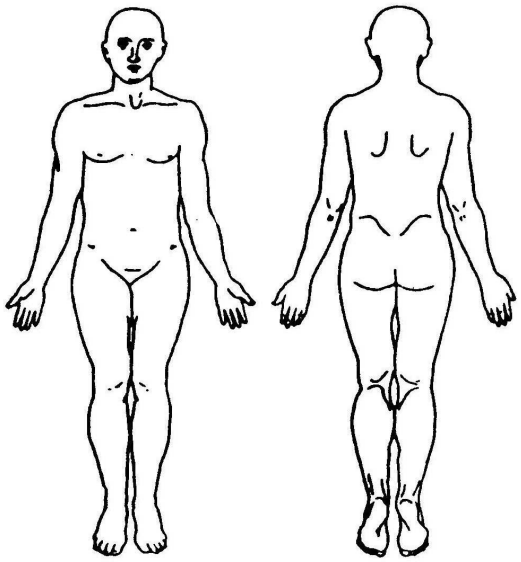
Please describe your symptoms: _____

_____

When did you first notice your current symptoms? _____

Location:

Please note on this diagram with an "X" where your symptoms are occurring:



Quality of Symptoms:
(What does it feel like?)

- ☐ Dull
- ☐ Achy
- ☐ Numbness
- ☐ Tingling
- ☐ Stiffness
- ☐ Sharp
- ☐ Cramping
- ☐ Nagging
- ☐ Sharp
- ☐ Burning
- ☐ Shooting
- ☐ Throbbing
- ☐ Stabbing
- ☐ Other_____

Prior Interventions: (What have you done to try and relieve the symptoms?) _____

_____

_____

How have your symptoms affected your daily activities or routines? _____

_____

Have you missed any work due to your symptoms? ☐ Yes ☐ No

Section 4: Previous Pregnancies/Births

Number of previous pregnancies: _____ Number of previous births _____

Your previous births were at a: ☐ Hospital ☐ Home ☐ Birth Center ☐ Other: _____

Medications used in prior births: ☐ None ☐ Ptocin ☐ Epidural ☐ Other: _____

Interventions used in prior births: ☐ Breaking of water ☐ Vacuum ☐ Forceps ☐ Episiotomy

☐ C-Section ☐ Other: _____

How long was your previous labor? Total: _____ Time before you pushed: _____

Did you have chiropractic care during your previous pregnancies? ☐ Yes ☐ No

Section 5: Complete only when you are past 32 weeks:

Position of baby: ☐ Head down ☐ Posterior ☐ Breech or malposistioned

Position confirmed by: ☐ Palpation ☐ Ultrasound on _____ /_____ / _____

How long do you believe baby has been in this position? _____

Section 6: Your Personal Health History

Review of systems: (Please mark all issues below that you have currently, or have had/been diagnosed with in the past.)
C=Current Issue, P=Past Issue, N=Never has been an issue

A. Musculoskeletal:					
Osteoporosis	☐C ☐P ☐N	Foot/Ankle Pain	☐C ☐P ☐N	Neck Pain	☐C ☐P ☐N
Knee Injuries	☐C ☐P ☐N	Scoliosis	☐C ☐P ☐N	Elbow/Wrist Pain	☐C ☐P ☐N
Arthritis	☐C ☐P ☐N	Shoulder Problems	☐C ☐P ☐N	Back Problems	☐C ☐P ☐N
Gout	☐C ☐P ☐N	Hip Disorders	☐C ☐P ☐N	TMJ Issues	☐C ☐P ☐N
B. Neurological					
Anxiety	☐C ☐P ☐N	Depression	☐C ☐P ☐N	Headache	☐C ☐P ☐N
Dizziness	☐C ☐P ☐N	Seizures	☐C ☐P ☐N	Numbness	☐C ☐P ☐N
ADD/ADHD	☐C ☐P ☐N	Confusion	☐C ☐P ☐N	Loss of Balance	☐C ☐P ☐N
C. Cardiovascular					
High Blood Pressure	☐C ☐P ☐N	High Cholesterol	☐C ☐P ☐N	Angina	☐C ☐P ☐N
Low Blood Pressure	☐C ☐P ☐N	Excessive Bruising	☐C ☐P ☐N	Poor Circulation	☐C ☐P ☐N
Irregular Heart Beat	☐C ☐P ☐N	Pacemaker	☐C ☐P ☐N	Stroke	☐C ☐P ☐N
D. Respiratory					
Asthma	☐C ☐P ☐N	Sleep Apnea	☐C ☐P ☐N	Hay Fever	☐C ☐P ☐N
Shortness of Breath	☐C ☐P ☐N	Pneumonia	☐C ☐P ☐N	Emphysema	☐C ☐P ☐N
E. Digestive					
Food Sensitivities	☐C ☐P ☐N	IBS	☐C ☐P ☐N	Constipation	☐C ☐P ☐N
Digestion Problems	☐C ☐P ☐N	Ulcer	☐C ☐P ☐N	Diarrhea	☐C ☐P ☐N
Gallbladder Disease	☐C ☐P ☐N	Hemorrhoids	☐C ☐P ☐N	Heartburn	☐C ☐P ☐N
F. Sensory					
Blurred Vision	☐C ☐P ☐N	Ringing in Ears	☐C ☐P ☐N	Hearing Loss	☐C ☐P ☐N
Chronic Ear Infection	☐C ☐P ☐N	Loss of Smell	☐C ☐P ☐N	Loss of Taste	☐C ☐P ☐N
G. Skin					
Skin Cancer	☐C ☐P ☐N	Eczema	☐C ☐P ☐N	Hair Loss	☐C ☐P ☐N
Psoriasis	☐C ☐P ☐N	Acne	☐C ☐P ☐N	Rash	☐C ☐P ☐N
E. Endocrine					
Thyroid Issues	☐C ☐P ☐N	Hot Flashes	☐C ☐P ☐N	Low Energy	☐C ☐P ☐N
Immune Disorder	☐C ☐P ☐N	Frequent Infection	☐C ☐P ☐N	Swollen Glands	☐C ☐P ☐N
F. Urinary					
Kidney Stones	☐C ☐P ☐N	Frequent Urination	☐C ☐P ☐N	Bedwetting	☐C ☐P ☐N
G. General					
Weight Gain/Loss	☐C ☐P ☐N	Low Libido	☐C ☐P ☐N	Eating Disorder	☐C ☐P ☐N
Appetite Changes	☐C ☐P ☐N	Cancer	☐C ☐P ☐N	Concussion	☐C ☐P ☐N
H. For Females Only:					
Difficulty Conceiving	☐C ☐P ☐N	Irregular Periods	☐C ☐P ☐N	Painful Periods	☐C ☐P ☐N
Breast Tenderness	☐C ☐P ☐N	Breast Implants	☐C ☐P ☐N	PMS Issues	☐C ☐P ☐N

Surgeries/Hospitalizations:
Have you had any of the following surgical interventions?
☐ Appendix Removal ☐ Bypass Surgery ☐ Cosmetic Surgery ☐ Elective Surgery _____
☐ Eye Surgery ☐ Hysterectomy ☐ Pacemaker ☐ Spinal Surgery _____
☐ Other _____

Injuries:
Do you have a history of any of the following?
☐ Fractured or broken bone
☐ Spine or nervous system disorder
☐ Being knocked unconscious
☐ Injury in an accident
☐ Other _____

Please list any medications you are taking with reason for use (prescription and over the counter):
_____
_____
_____
_____

Treatments:
Please check the treatments you have received in the past or are receiving currently:

Current	Past	
☐	☐	Acupuncture
☐	☐	Antibiotics
☐	☐	Birth Control Pills
☐	☐	Chemotherapy
☐	☐	Dialysis
☐	☐	Herbal Remedies
☐	☐	Homeopathy
☐	☐	Hormone Replacement Therapy
☐	☐	Massage Therapy
☐	☐	Physical Therapy
☐	☐	Other: _____
		_____

Please list any nutritional supplements/vitamins you are currently taking:
_____
_____
_____
_____

Section 7: Personal Health Habits & Lifestyle

Tell us about your health habits and stress levels.

Alcohol	☐ Daily ☐ Weekly ☐ Occasionally ☐ Never	How much? _____
Coffee Use	☐ Daily ☐ Weekly ☐ Occasionally ☐ Never	How much? _____
Energy Products	☐ Daily ☐ Weekly ☐ Occasionally ☐ Never	How much? _____
Soft Drinks	☐ Daily ☐ Weekly ☐ Occasionally ☐ Never	How much? _____
Drugs	☐ Daily ☐ Weekly ☐ Occasionally ☐ Never	How much? _____
Tobacco	☐ Daily ☐ Weekly ☐ Occasionally ☐ Never	How much? _____
Exercise	☐ Daily ☐ Weekly ☐ Occasionally ☐ Never	How much? _____
Water	☐ Daily ☐ Weekly ☐ Occasionally ☐ Never	How much? _____

Please rate your stress level on a scale from 0-10 (0=no stress and 10=extremely high stress): _____

Section 8: General

Is there any additional information you would like us to know about you and your pregnancy?

_____

_____

_____

THE WEBSTER TECHNIQUE DEFINED

International Chiropractic Pediatric Association definition of Webster Technique:
The Webster technique is a specific chiropractic analysis and adjustment that reduces interference to the nervous system, balances out pelvic muscles and ligaments which in turn removes torsion to the uterus, reducing the potential for intra-uterine constraint and allows the baby to get into the best possible position for birth.

Section 9: Acknowledgements

To set clear expectation, improve communication and help you get the best results, please read each statement and initial your agreement.

I understand that Cristina Poulos, DC provides chiropractic adjustments, which address musculoskeletal complaints in patients, including pregnant women. _____ (initial)

I instruct the chiropractor to deliver the care that, in her professional judgment, can best help me in my restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine, and does not proclaim to cure any named disease or entity. _____ (initial)

I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected. _____ (initial)

I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office. _____ (initial)

I acknowledge that I am responsible for the timely payment of any and all services I receive. _____ (initial)

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern or health issues. _____ (initial)

Signature: _____ Date: _____ /_____ / _____