



54 Crossing Blvd. Ste. H
Clifton Park, NY 12065
518.383.5595
www.ForLifetimeWellness.com

Welcome, Mommy-to-be, to Ferguson Family Chiropractic!

* The information contained herein is strictly confidential between the patient and Ferguson Family Chiropractic. Although all the questions are valuable to assess your overall health, you may exercise the option to forgo any of the questions as you see fit.

Name: _____ Today's Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Occupation: _____ Employer: _____

Marital Status: _____ Spouse/Significant Other's Name: _____

No. of children: _____ Due Date (Mo/Day/Yr): _____

Insurance Plan _____ #: _____

Date of Birth (Mo/Day/Yr): ____/____/____

Who may we thank for referring you to our office?

Reason for today's visit: _____

Have you had previous chiropractic care? Yes ___ No ___ Reason for leaving? _____

Name of previous chiropractor: _____ Date of last visit: _____

Who are your chosen birth attendants? Midwife ___ Obstetrician ___ Doula ___ Chiropractor ___

Name of birth attendants: _____

Date of last visit: _____

Chosen Location of Birth: Hospital _____ Birthing Center _____ Home ___ Other _____

Present MD: _____ Present OBGYN: _____

Have you ever had spinal x-rays done before? Yes ___ No ___ If yes, when and where? _____

Chiropractors work to create balance within the nervous system so that the mother and baby can have the best possible pregnancy from before pregnancy, to the birth and after. Different stressors create interference to the way that the nervous system is working. These include physical (ie. posture, falls, accidents, etc.), emotional (ie. finances, divorce, relationships, etc.) and chemical stressors (ie. over the counter medications, prescription medications, vaccines, alcohol, drugs, poor diet, etc.).

What type of physical stressors have you experienced in life/during pregnancy?

What type of emotional stressors have you experienced in life/during pregnancy?

What type of chemical stressors have you experienced in life/during pregnancy?

How do you grade your physical health? Excellent ___ Good ___ Fair ___ Poor ___ Getting Better ___ Getting Worse ___

How do you grade your emotional-mental health? Exc ___ Good ___ Fair ___ Poor ___ Getting Better ___ Getting Worse ___

How do you grade your spiritual health? Excellent ___ Good ___ Fair ___ Poor ___ Getting Better ___ Getting Worse ___

How do you rate your occupational stress (1-10, 10 being the most stressful) _____

Planned maternity leave? _____ If so, starting when? _____

How would you describe your connection with your baby? _____

How active is your baby? Can't feel baby move at all ____ slow but moving ____ active ____ very active ____
other (please describe) _____

Describe any complications during this (or previous pregnancy) and when they occurred: _____

Any exposures to ultrasound during this pregnancy? _____ How many? _____

Were you told that you had a choice in vaccinating your child? ____ YES ____ NO

Would you like information on the other side of this issue? ____ YES ____ NO

Other Symptoms (please check if you currently are experiencing or have experienced within the past 6 months):

- | | | | | |
|---|---|---|--|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Irritability | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Face Flushed |
| <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Numbness in Fingers | |
| <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Depression | <input type="checkbox"/> Light Bothers Eyes |
| <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Ears Ring | <input type="checkbox"/> Fever | <input type="checkbox"/> Fainting | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Feet Cold | <input type="checkbox"/> Hands Cold |
| <input type="checkbox"/> Stomach Upset | <input type="checkbox"/> Constipation | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Buzzing in Ear | <input type="checkbox"/> Ear Infections |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Allergies | <input type="checkbox"/> Frequent colds/flu | <input type="checkbox"/> Previous Menstrual problems | |
| <input type="checkbox"/> IBS/Crohn's disease | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Other Conditions/diseases: _____ | | | | |

If you have had a previous pregnancy did you have or experience any of the following with your labor:

Hospital birth ____ home birth ____ birthing center birth ____ Other birth location ____ Epidural ____
episiotomy ____ induction ____ breech presentation ____ back labor ____ forceps ____ c-section ____
vacuum extraction ____ fetal scalp monitoring ____ other intervention _____

During the day I: sit ____ stand ____ walk ____ do desk work ____ on the phone often ____ drive ____ heavy lifting ____

How would you describe your:

- Diet ____ Poor ____ Good ____ Excellent
 Sleep ____ Poor ____ Good ____ Excellent
 Exercise ____ Poor ____ Good ____ Excellent

I exercise: _____ times a week, doing the following activities _____.

Were you, or are you active in any particular sport(s) or fitness activities? Yes ____ No ____

Which ones? _____

Have you been hurt in any of these activities? Yes ____ No ____

List all falls, accidents and injuries you have had and give dates:

Have you ever been hospitalized? Yes ____ No ____

If yes, what was actually done to you?

If we were able to find the cause of your problem and get rid of it, please rate your level of commitment in helping us do this (on a scale of 1 to 10, with 10 being the highest): _____

Upon the completion of your first visit, you will receive a Chiropractic Report to discuss the different types of care that are available to you. Chiropractic is designed to help get you feeling better quickly and to help you and your family be as healthy as possible. Please review the explanations of the care options below prior to your Chiropractic Report appointment so you can choose the level of participation that supports you in reaching all of your health goals.

As a result of my chiropractic care, I would like to (**Please check all that apply**):

- Feel better quickly Have a healthier spine Have a healthier pregnancy Have a more satisfying labor
 Have a healthier body by keeping my nerve system healthy Live a healthier lifestyle Turn my breech baby

Signature _____

Date _____