PATHWAYS Moms
FAMILY CHIROPRACTIC

PERSONAL INFORMATION

Name : _____ Preferred Name: _____ Date: MM/DD/YYYY

Address: _____

City / Prov / Postal Code: _____

Home #: _____ Cell #: _____ Work #: _____

E-Mail Address: _____

Birthday : MM/DD/YYYY Age: ____ Gender: M / F

Marital Status: S D W M Spouse / Partner's Name: _____

Employer: _____ Occupation : _____

Children

Name _____ Age: ___ Gender: M / F Name _____ Age: ___ Gender: M / F

Name _____ Age: ___ Gender: M / F Name _____ Age: ___ Gender: M / F

Who may we thank for referring you to our office? / or / How did you choose us?

- ☐ Family/ Friend (name) _____
- ☐ Website/Facebook(circle one)
- ☐ Workshop (which group) _____
- ☐ Health Practitioner _____
- ☐ Walk -in
- ☐ Print Advertisement _____
- ☐ Other _____

CHIROPRACTIC HISTORY

Have you been to a chiropractor before? No ___ Yes ___ Date of last visit: _____

Has a family member previously seen a chiropractor? No ___ Yes ___ if yes, Spouse ___ Sibling ___ Child ___

Name of chiropractor: _____

Reason for seeing them: _____

Describe your experience? _____

How frequently did you go for adjustments? _____

What made you decide not to return? _____

For Office Use Only

CORE: _____ Hx: _____ G: _____

C: _____ _____ _____

L: _____ _____ _____

Due Date: _____

Do you currently have a, please list their name: OBGYN _____ Midwife _____

Doula _____ Naturopath _____

Do you have questions regarding:

Breast Feeding	Diet and Supplementation	Home Birth	Massage
Birth Trauma	Dystocia	Sleeping positions	Medications
Breech Baby	Excercising	Ultrasounds	Medical Interventions
Community Resources	Fevers	Vaccinations/shots	Multiple Babies
Childhood Development	Formula	VBAC	Postpartum
Delivery Positions	Genetic Diseases	Water Birth	Parenting
Due Date Suggestions	Illness	Rights as a woman	
		Yoga	

Are/will you be attending a prenatal class with or without your spouse? ___YES ___NO

Do you currently participate in a prenatal exercising/ yoga program ? ___YES ___NO

Are you taking dietary supplements ? ___ YES ___NO

If so, which ones? :_____

Describe your sleeping patterns (ex:# hours, position, intermittent or through the night)

_____

PREVIOUS PREGNANCY and BIRTH HISTORY

How many pregnancies have you had? _____ **IF this is your first pregnancy mark N/A**

Have you had any miscarriages ? ____No ____Yes How many? _____

During pregnancy did the mother:

Smoke? ___No ___Yes How much? _____

Drink? ___No ___Yes How much? _____

Any ultrasounds or other radiation? ___No ___Yes

If so, how many and for what reasons? _____

Were there any invasive procedures during the pregnancy (amniocentesis, CVS etc.)? ___ No ___Yes

Please explain _____

Trauma/ illness during pregnancy _____

Please describe any emotional stress the mother experienced during the pregnancy: _____

_____

Position during labour: ___ On back ___ Side ___ Sitting ___ Standing

Was labour induced? ___ No ___Yes

Did the mother have an episiotomy? ___ No ___Yes

Was monitoring used? ___ Internal ___External

Location of birth? ___ Home ___Hospital ___Birthing center

Birth assistants? ___ Midwife ___Doula ___Medical Doctor ___ None

How many hours did labour last? _____

Was the mother administered any drugs? ___ Epidural ___ Morphine ___ Other _____

Was there any assistance used during birth? ___ No ___Yes: ___Forceps ___Caesarean ___Vacuum extraction

Was there any evidence of birth trauma to the infant? Check all that apply:

___Bruising	___Stuck in birth canal	___Respiratory depression
___Odd shaped head	___Fast or excessively long birth	___Cord around neck

Were there any other complications during birth or Congenital anomalies/ defects present? ___No ___Yes

Please explain: _____

HEALTH CONCERNS – FILL IN **ALL** AREAS

Please check (√) all that you have experienced in the last **12 months**

- ☐ Acne
- ☐ ADD/ADHD
- ☐ Allergies _____
- ☐ Anxiety
- ☐ Asthma
- ☐ Autism
- ☐ Back pain (circle area) Upper/Mid/Low
- ☐ Balance/Coordination
- ☐ Bladder
- ☐ Cancer
- ☐ Chest Pain
- ☐ Chronic Cough
- ☐ Chronic Fatigue
- ☐ Colds
- ☐ Congestion
- ☐ Constipation
- ☐ Cramps
- ☐ Depression
- ☐ Diabetes
- ☐ Diarrhea
- ☐ Dizziness
- ☐ Ear Infections/Aches
- ☐ Eczema
- ☐ Epilepsy/Seizure
- ☐ Eye Pain
- ☐ Food Allergies
- ☐ Gallbladder issues
- ☐ G.I. Issues
- ☐ Hand/Wrist Pain
- ☐ Headaches
- ☐ Heart Disease
- ☐ Hernias
- ☐ High Blood Pressure
- ☐ Hip Pain
- ☐ Insomnia
- ☐ Irregular Cycles
- ☐ Jaundice
- ☐ Kidney issues
- ☐ Knee/Ankle/Foot Pain
- ☐ Menstrual Cramps
- ☐ Metabolism issues
- ☐ Migraines
- ☐ Neck/ Shoulder Pain
- ☐ Pneumonia/Bronchitis
- ☐ Poor Circulation
- ☐ Prostate issues
- ☐ Reflux
- ☐ Reproductive issues
- ☐ Sensory Processing/ Spectrum disorder
- ☐ Skin issues
- ☐ Sleep issues
- ☐ Speech problems
- ☐ Throat issues
- ☐ Thyroid issues
- ☐ Tinnitus /Ringing Ears
- ☐ Vertigo
- ☐ Other: _____
- ☐ Other: _____

Special Note: Have you taken any medication within the last 24 hours? No ___ Yes ___

Please List: _____ _____

Which one of the above is your main concern and brought you to our office? _____

On a scale of 1 - 10 (10 being severe), how bad is the problem? _____ / 10

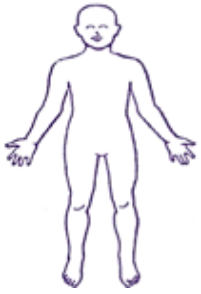
When did it start? _____ How? _____

Is it ? getting better ___ getting worse ___ staying the same

How would you describe the problem? _____

Are you taking medication for this condition? No___ Yes___ Please List: _____

Where is the problem? Please circle or draw on the illustrations and explain or describe your present condition in the lines below (i.e. sharp, dull, burning, tight, throbbing…).



Front _____

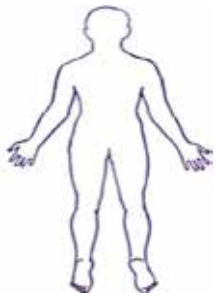
_____

_____

Back _____

_____

_____



What makes it worse? _____

What makes it better? _____

What else have you tried and what were the results? _____

What parts of your life is this condition interfering with: Work ___ Sleep ___ Exercise ___

Positive mental attitude ___ Hobbies ___Other _____

Which part of your life is most important for you to get back to ASAP? _____

Beyond feeling better, what are your top 3 goals for getting healthier?

1) _____

2) _____

3) _____

Fill out ALL detail below for the 3 most concerning conditions that you checked off on the last page:

#1:_____

On a scale of 1 -10 (10 being severe), how significant is the problem? _____/ 10

When did it start? _____ How? _____

Is it ? getting better ____ getting worse ____ staying the same ____

Describe the problem? _____

Are you taking medication for this condition? No____ Yes____ Please List: _____

#2:_____

On a scale of 1 -10 (10 being severe), how significant is the problem? _____/ 10

When did it start? _____ How? _____

Is it ? getting better ____ getting worse ____ staying the same ____

Describe the problem? _____

Are you taking medication for this condition? No____ Yes____ Please List: _____

#3:_____

On a scale of 1 - 10 (10 being severe), how significant is the problem? _____/ 10

When did it start? _____ How? _____

Is it ? getting better ____ getting worse ____ staying the same ____

Describe the problem? _____

Are you taking medication for this condition? No____ Yes____ Please List: _____

Special Note: Have you taken any medication within the last 24 hours? No____ Yes____

Please List: _____ _____

What parts of life is this interfering with: School ____ Sleep____ Play ____ Hobbies ____ Exercise ____

Positive mental attitude ____ Oth er_____

Which part of life is most important to get back to ASAP? _____

Beyond feeling better, what are the top 3 goals for getting healthier?

1) _____

2) _____

3) _____

PATHWAYS
FAMILY CHIROPRACTIC

Informed Consent to Chiropractic Treatment

There are risks and possible risks associated with manual therapy techniques used by doctors of chiropractic. In particular you should note:

a) While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures;

b) There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke. Recent studies suggest that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote;

c) There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or other chiropractic treatment;

d) There are infrequent reported cases of burns or skin irritation in association with the use of some types of electrical therapy offered by some doctors of chiropractic.

I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general, (including spinal adjustment), the treatment options and recommendations for my condition, and the contents of this Consent.

I consent to the chiropractic treatment recommended to me by my chiropractor including any recommended spinal adjustments.

I intend this consent to apply to all my present and future chiropractic care.

Dated this_____day of_____, 20_____.

_____ _____

Patient Signature (Legal Guardian) **Witness of Signature**