Café of Life
Chiropractic

Pregnancy Health History Form

Name: ______________________________________ Date:____________________________
Age: ______ Birth date: dd/mm/yyyy ______________ Sex: F Patient Number: ___
E mail address: ____________________________________
Address:____
Phone:(H)__________ (W)__________ (cell) _____________ Marital Status: S M W D CL
Occupation: _______________________ Who may we thank for referring you?___________
Family doctors name and address: ____

WHY THIS FORM IS IMPORTANT: Our focus is on assisting clients to function optimally, for them to become more self-aware, stronger, healthier and for improved adaptation to everyday stresses. Completion of this form provides us with an improved understanding of your physical, emotional and chemical stresses that can gradually overwhelm the body over time and contribute to health problems. Please complete this form as thoroughly as possible and the doctor will review it with you. Information on this form is strictly confidential and will not be shared without your consent.

#1 Current Health Concern (if there are no current concerns and this assessment is to ensure optimum health, function and wellness tick this box) ☐

 # 2 About Your Pregnancy: (circle answer)
Is this your first pregnancy? **Yes / No**
If this is not your first, how many times have you been pregnant? _______
Have you had any complications with previous pregnancies? **Yes / No** (explain if yes)
____
If you have had miscarriage(s), how far along in your pregnancy did it occur?
____
Was this pregnancy planned? **Yes / No**
What is the estimated date of delivery? ______________________________________
Who is your primary care giver for delivery? Obgyn / GP/ Midwife? Name: ____________
What is your planned location for delivery? Hospital / Home/ Birthing clinic/other
How do you feel about this pregnancy? _______________________________________
Have you a birth plan? **Yes / No**
Would you like information on creating one? **Yes / No**
Any special arrangements for the birth? (planned C-sec, water delivery, birth chair, squat, other)____
Would you like additional information on options for birth posturing? **Yes / No**
Have you had any testing? Genetic, blood, ultrasound, amniocentesis, chorionic villi sampling, other)?
Dates and reasons: ____
Are you planning on breastfeeding post delivery? **Yes / No**

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Would you like further information on the advantages of breastfeeding? **Yes / No**
Was you blood pressure prior to pregnancy within normal range, low or high? _________
What is your present blood pressure and when was it last checked? _________________
Have you changed your diet/menu since learning of your pregnancy? **Yes / No**
Would you like further information on healthy nutrition for pregnancy? **Yes / No**
Have you smoked prior to or along with this pregnancy? **Yes / No / Quit** _____________
Have you had alcohol during this pregnancy? **Yes / No** ____________________________

Have you noticed:
Swelling in the arms or legs? (circle) **Yes / /No**
Low back pain? **Yes / No** How often? ____
Upper back pain? **Yes / No** How often? ______________________________________
Neck pain? **Yes / No** How often? ____
Rib or chest pain? **Yes / No** How often? _____________________________________
Any foot pain? **Yes / No** How often? ____
Digestive complaints? Heartburn, constipation? **Yes/ No** _________________________
Nausea or vomiting? **Yes / No** Frequency and when? ____________________________
Arm or hand numbness/tingling? **Yes / No** How often? __________________________
Dizziness or lightheadedness? **Yes / No** How often? ____________________________
Headaches? **Yes / No** How often?
Pain radiating down the leg(s)? **Yes / No** How often? ___________________________
Heart palpitations? **Yes / No** How often? _____________________________________

If pain from anything noted above is involved, rank it on a scale of 1 to 10 (1 is minimal, 10 is extreme) ______________
Circle or describe it's character (sharp, dull, ache, burning, tingling, throbbing, spasms, other) _______________________________
When did you notice it?_________________
What happened? _____________________ What relieves?_____________________ What aggravates?_________________________
Does it radiate or cause problems elsewhere? __________________________________
Any associated or related concerns? ____
Professionals seen for this? (name) ____
Treatment and results____

Other health concerns: Please note all other health concerns present or in the past.
Diseases history: (please circle all that apply)
Allergies, Stuffy nose, Runny sinuses, Frequent colds, Lowered resistance, Loss of balance, Difficulty concentrating, Fatigue, Indigestion, Bloating, Appendicitis, Asthma, Bronchitis, Emphysema, Pneumonia, Bleeding disorders, Cancer, Cataracts, Vision changes, Diabetes, Hypoglycemia, Epilepsy, Heart Disease, Hypertension, Migraines, Hepatitis, High cholesterol, Difficulty digestion, Loose stools, Hernia,

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Herniated Disc, Kidney Disease, Liver disease, Multiple Sclerosis, Osteoarthritis, Rheumatoid arthritis, Osteoporosis, Parkinson's Disease, Thyroid problem, Tonsillitis, Ulcers, Urinary tract infections, Ulcerative colitis Other (list):

____

#3 Physical stresses

Any significant injuries, falls or traumas during infancy or childhood? **Yes No Unsure**
(if yes please explain) ____ Any significant injuries, falls or traumas (car accidents) during adulthood? **Yes No Unsure**
(if yes please explain) ____ Any hospital visits? **Yes No** Explain____ Have you had any surgeries, fractures? **Yes No** Explain and dates

____

Are you in prolonged postures (ex: repetitive work, lifting, sitting, driving) **Yes No Unsure**
(if yes, please explain)____ Any hobbies that are physically strenuous or have repetitive movements? **Yes No Unsure**
(if yes, please explain)____ What is your usual exercise routine? ____
Any fractured bones or dislocations? ____
Any vehicle accidents? **Yes No** What happened and when? __________________________

#4 Chemical Stresses

Are you taking prescription or over-the-counter medications? **Yes / No (**If yes, please indicate what you are taking and why) ____
Are you currently taking supplements? **Yes / No**(if yes, which ones and why?) ____________
____Do you drink bottled water? **Yes / No / Occasionally**
Are you exposed to pollutants, strong smells, chemicals, aerosols? **Yes No Occasionally**
Do you eat organic? **Yes / No / Occasionally**
Do you use natural or environmentally friendly products in your home? I.E. Cleaning supplies, hair and makeup, etc. **Yes / No** ____
Do you drink or bathe/shower in chlorinated water? **Yes / No** _______________________

#5 Mental/Emotional Stresses

Since psychological stress has been shown to affect numerous systems and fetal function, please let us know how you are coping with life's stresses. Rank from 1 to 10 with 1 being minimal to 10 being extreme)
Life in general I feel ______ Work and Career I feel _____ Relationships I feel ______
Financial stress I feel _____ Time management I feel ____ Sports & hobbies I feel ___
Health and well-being I feel ____ Quality of sleep I feel ____ About my pregnancy I feel _
If you are experiencing significant or ongoing stress please explain ____________________

____

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Do you practice some form of meditation, breath work, other mind-body movement or have a routine to reduce your stress? **Yes /No** Explain ____
Are you interested in learning about stress reduction practices? **Yes / No**

#6 Family Health History
Please note any health issues that are present with family members such as parents, siblings, significant other or children. Cancer, hypertension, stroke, arthritis, kidney disease, dementia, diabetes, other
____

#7 Why are you here?

People seek chiropractic care for a number of reasons and have certain expectations and perceptions. Please tick the goals which apply to you so we can accommodate your wishes.

Improvement in function ___ Pain reduction ___ Relief ___ Improved quality of life ____
Manage my crisis___ Information on prevention ___Symptom management ____
Healthier immune system ___ Stress reduction ___ Keep me moving___ Optimum function and quality of life ___ Improved performance ____ Full body integration____ Wellness ____ Longevity ______________ Other____

CONSENT for examination and care once a report of findings has been reviewed: Please Read Carefully

In order for my health professional as indicated below to make a determination on the suitability of my case for care, I acknowledge and understand that I must complete a thorough evaluation. I do hereby request and consent to the performance of such an evaluation by the person(s) named below, or any party authorized to do so by that person.

I have had the opportunity to discuss with the Doctor of Chiropractic indicated below, or with any party authorized to do so by that Chiropractor, about the nature and purpose of the examination process. I understand that there may be remotely associated risks with examinations, as there are with any and all healthcare treatments. In healthcare, the matter of whether any treatment is appropriate or not is determined by looking at the level of risk and comparing this with the level of expected benefit. I understand that I may ask the doctor to stop the examination at any time. I also understand that by signing this form, the chiropractor continues to be obligated for best practices delivered in my interests.

Name: ______________________________ Date:_________________________

Signature:________________________ **Witness:**______________________

Doctor of Chiropractic: Dr. Shaian Mollaret
Address: 32 Berwick Ave, Suite 201, Toronto, ON M5P 1H1

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Finances

Payment in full is expected on all FIRST VISIT services (whether you have insurance coverage or not.) All other fees are to be paid at time of service until other arrangements have been made and agreed upon in writing.

Please indicate your method of payment. ❑ Cash ❑ Debit Card

First Visit Fees: Comprehensive Exam: $100 X-Rays (if necessary): $30
Doctor's Report (Second Visit): $50 Adjustments/Entrainments: $47