Miano Family Chiropractic Center, LLC

PRENATAL HISTORY

NAME: _____ DATE: _____

YOUR PRENATAL CARE:

What is your due date?: _____ How many weeks are you currently?: _____

Who is your Prenatal Care Provider(s)?: _____

Can we contact their office to update them about your care at our office: ◊ Yes ◊ No

When was your last examination with your Prenatal Care Provider?: _____

What is the current schedule you visit with your Prenatal Care Provider?: _____

YOUR ANTICIPATED DELIVERY:

Do you have a scheduled delivery?: ◊ No ◊ Yes If yes, why:_____

Where are you planning to deliver?: _____

Are you planning for a drug-free delivery, or for an epidural?: ◊ Drug-free ◊ Epidural ◊ Not Sure Yet

Are you planning to take a childbirth class?: ◊ No ◊ Yes If yes, where:_____

Are you planning to take a breastfeeding class?: ◊ No ◊ Yes If yes, where:_____

Are you planning to take a newborn care class?: ◊ No ◊ Yes If yes, where:_____

YOUR PREGNANCY TO DATE, HAVE YOU:

Experienced any fertility issues while trying to conceive? ◊ No ◊ Yes If yes, please describe: _____

_____

Had ultrasound exams?: ◊ No ◊ Yes If yes, how many: _____

Experienced morning sickness?: ◊ No ◊ Yes If yes, please describe: _____

Experienced fatigue?: ◊ No ◊ Yes If yes, please describe: _____

Experienced digestive upset?: ◊ No ◊ Yes If yes, please describe: _____

Taken any medications?: ◊ No ◊ Yes If yes, please describe: _____

Consumed alcohol?: ◊ No ◊ Yes If yes, please describe: _____

Smoked tobacco / other?: ◊ No ◊ Yes If yes, please describe: _____

Ingested "street drugs"?: ◊ No ◊ Yes If yes, please describe: _____

Experienced any complications during pregnancy?: ◊ No ◊ Yes If yes, please describe: _____

_____

Experienced any injuries during pregnancy?: ◊ No ◊ Yes If yes, please describe: _____

_____

YOUR OBSTETRIC HISTORY:

Including this pregnancy, what is your Total number of Pregnancies: _____ Live Births: _____

Were there any issues during past pregnancies, labors, and/or deliveries?: ◊ No ◊ Yes

If yes, please describe: _____

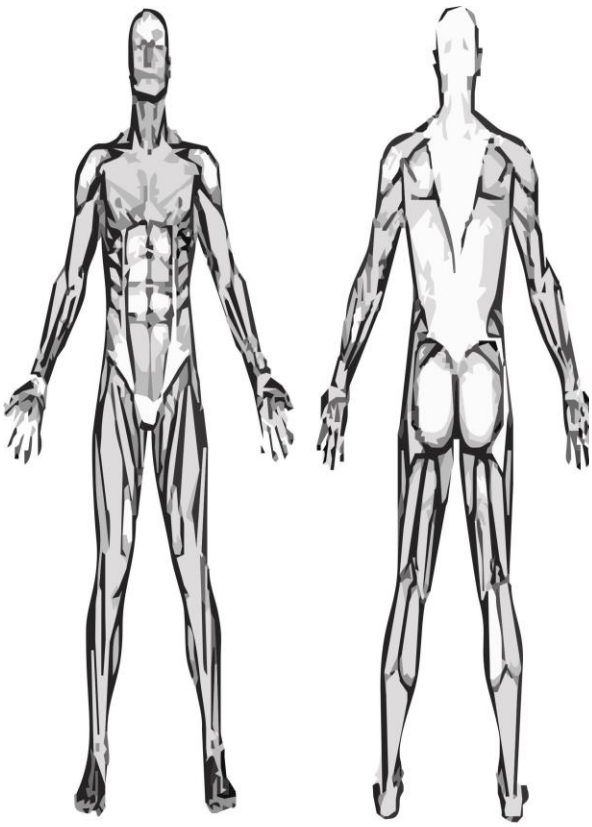
_____

NAME: _____ DATE: _____ **CASE HISTORY (PAGE 2)**

Primary Reason For Today's Visit: _____

When Did Your Problem Begin: _____ How: _____

PLEASE CIRCLE YOUR AREA(S) OF COMPLAINT:



Please give a number to grade your pain: _____
(1 = no pain → 10 = Unbearable Pain)

Please circle all words that describe your pain:
Dull Ache Stiff Spasm Sharp Shooting
Tingling Weakness Other:_____

Please circle how often your pain is present:
Constant (100 – 81%) Frequent (80 – 51%)
Occasional (50 – 26%) Intermiten (25 – 0%)

Since your pain began, it is:
Getting Worse Getting Better Staying the Same

Circle any/all of the listed that **BRINGS RELIEF**:
Nothing Standing Sitting Heat Cold Stretching
Lying Down Moving Around Other:_____

Circle any/all of the listed that **MAKES YOU WORSE**:
Nothing Standing Sitting Heat Cold Stretching
Lying Down Moving Around Other:_____

Have you sought medical treatment for this condition?: _____

Have you had an episode like this in the past?:_____

Has your condition made it more difficult to:

◊ Take Care of Yourself and/or Other People
◊ Work *(If out of work, what dates: _____)*
◊ Fall Sleep / Stay Asleep / Wake up well rested
◊ Participate in Exercise / Sports
◊ Perform your Daily Responsibilities
◊ Attend School *(If out, what dates: _____)*
◊ Drive *(Long Distances and/or Short Distances)*
◊ Participate in Hobbies
◊ Other: _____

Do you have any other painful or chronic conditions that affect you daily or periodically?:

_____

_____

_____

NAME: _____ DATE: _____ **FAMILY HISTORY (PAGE 3)**

FAMILY HISTORY

PLEASE LIST THE AGES OF THE FOLLOWING FAMILY MEMBERS *(IF DECEASED, PLEASE LIST AGE AT DEATH)*:

Mother: _____ Father: _____ Living Grandparents: _____

Siblings: _____ _____ _____ _____ _____

Children: _____ _____ _____ _____ _____

PLEASE CIRCLE IF YOU AND/OR AN IMMEDIATE FAMILY MEMBER HAS ANY OF THE BELOW LISTED CONDITIONS NOW OR IN THE PAST

MUSCULO / SKELETAL REVIEW:

Arthritis Self Child Parent Sibling Grandparent

Osteoporosis / Osteopenia Self Child Parent Sibling Grandparent

Headaches Self Child Parent Sibling Grandparent

Scoliosis Self Child Parent Sibling Grandparent

Neck Pain / Back Pain Self Child Parent Sibling Grandparent

Pain: Shoulder/Arm/Hand, Leg/Foot Self Child Parent Sibling Grandparent

Paralysis / Vertigo Self Child Parent Sibling Grandparent

SYSTEMIC REVIEW / NEUROLOGICAL DISEASE:

Cancer Self Child Parent Sibling Grandparent

Diabetes Self Child Parent Sibling Grandparent

Stroke / Epilepsy Self Child Parent Sibling Grandparent

Parkinson's / Alzheimer's / MS Self Child Parent Sibling Grandparent

Anxiety / Depression / ADD/ ADHD/ ODD Self Child Parent Sibling Grandparent

RESPIRATORY REVIEW:

Asthma / Lung Disease Self Child Parent Sibling Grandparent

Seasonal Allergies Self Child Parent Sibling Grandparent

CARDIAC REVIEW:

Heart Disease / Blood Pressure Issuse Self Child Parent Sibling Grandparent

Circulatory Disease/Disorder Self Child Parent Sibling Grandparent

DIGESTIVE REVIEW:

Do you have a Bowel Movement daily Yes / No

Allergies / Sensitivities(Food) Self Child Parent Sibling Grandparent

Excessive Thirst / Heartburn Self Child Parent Sibling Grandparent

Frequent Nausea/Vomiting/ Diarrhea/Constipation Self Child Parent Sibling Grandparent

GENITO / URINARY REVIEW:

Kidney Stones / Infection / Frequent UTI Self Child Parent Sibling Grandparent

Menstrual Symptoms / Reproductive Challenges Self Child Parent Sibling Grandparent

REVIEW OF SYSTEMS & INFECTIOUS DISEASE:

Frequent Influenza / Pneumonia / Bronchitis Self Child Parent Sibling Grandparent

Vision Problems/Eye Disease Self Child Parent Sibling Grandparent

Dental Problems / TMJ Self Child Parent Sibling Grandparent

Ear Infections / Hearing loss / Tinitis Self Child Parent Sibling Grandparent

Fatigue / Disrupted Sleep Self Child Parent Sibling Grandparent

NAME: _____ DATE: _____ **HEALTH HISTORY (PAGE 4)**

PERSONAL HEALTH CARE HISTORY:

When was your last examination with your Primary Care Physician: _____

If you were not diagnosed "In Good Health", what was wrong: _____

Have you / do you currently work with any of the following types of providers?:

Acupuncturist Naturopath/Homeopath Massage Therapist PT/OT Psychotherapist

Are you currently seeing another provider for an acute or chronic condition?: Yes No

If yes, please list why: _____

Have you been under the care of any other Chiropractor in the past?: Yes No

If yes, please list why: _____

Have you been brought to a hospital for any reason (other than childbirth)**?: Yes No**

If yes, please list why: _____

Please indicate if you have had any of the following surgeries:

◊ Spine ◊ Tonsils ◊ Tubes in Ears ◊ Cardiac ◊ Gastric Bypass

◊ Gall Bladder ◊ Appendix ◊ Hernia ◊ Extremity ◊ Joint Replacement

Other: _____

Please indicate how often you exercise: _____ days / wk

What type of exercise do you do?: _____

Please tell me about your food and water intake:

How many oz of water do you drink daily?: _____ What is your approximate weight?: _____ lb

Do you follow a special diet?: ◊ No ◊ Yes If yes, what: _____

Please tell me about your bed / sleep habits:

What type of mattress do you have?: Foam Coil Other: _____ How old is it?: _____ yrs

Do you sleep on your: SIDE or BACK or BELLY Do you use a body pillow: Yes No

Females only:

First date of last period: _____ Are you currently pregnant?: Yes No

QUALITY OF LIFE EVALUATION:

How do you rate your present **General Health**?:	◊ Excellent	◊ Good	◊Fair	◊Poor
How do you rate your ability to **Handle Stress**?:	◊ Excellent	◊ Good	◊Fair	◊Poor
How do you rate your overall **Quality of Life**?:	◊ Excellent	◊ Good	◊Fair	◊Poor

GOALS FOR CARE:

I hope to see the following benefits from Chiropractic Care: *(Check all that apply)*

◊ Relief of a symptom or problem

◊ Relief & Prevention of a symptom or problem

◊ Healthier spine & nervous system

◊ Optimal health overall

STRESS PROFILE:

THERE ARE THREE TYPES OF **STRESS** THAT WILL AFFECT THE **SPINE & NERVOUS SYSTEM**:
EMOTIONAL STRESS, CHEMICAL STRESS, AND PHYSICAL STRESS

EMOTIONAL STRESS:

Have you experienced any of the following stressors: (past and/or present):

◊ Chronic Illness *(self or family)* ◊ Childhood Trauma ◊ Abuse
◊ Workplace Stress ◊ School Stress ◊ Major Lifestyle Change
◊ Divorce / Separation ◊ Loss of a Loved One ◊ Financial Stress

◊ Other: _____

CHEMICAL STRESS:

Please indicate any exposure you may have had to the following (past and/or present):

Daily Habits:
Caffeine: _____oz/ day Alcohol: ____oz/wk Tobacco: _____packs/day OTC: _____/wk

Environmental Exposure:
◊ Second Hand Smoke ◊ Toxic Chemicals ◊ Radiation Therapy ◊ Chemotherapy

Medications:
◊ Nerve Pills / Pain Killers / Muscle Relaxers ◊ Blood Pressure ◊ Insulin ◊ Aspirin/Similar
◊ Mood/Anxiety/Depression ◊ ADD/ADHD ◊ Birth Control ◊ Other: _____

PHYSICAL STRESS:

Please answer the following to the best of your ability:

Repetitive Physical Stress:
How long do you spend in a car on an average weekday: _____hours/day (Driver or Passenger)
How long do you spend in front of a computer / laptop / on a handheld device: _____hours/day
Do you spend more than 2 – 3 hours per day: seated at a desk standing lifting/carrying
Are you responsible for the daily care of another person: # of children: # of adults:

Major Trauma:
Have you been treated for any physical injuries in the past year?: ◊ No ◊ Yes
Have you been a passenger or driver in a car/truck accident?: ◊ No ◊ Yes
Have you been a passenger or driver in a bus/train accident?: ◊ No ◊ Yes
Have you participated in Sports as a child or an adult?: ◊ No ◊ Yes
Have you had any Sports Injuries as a child or an adult?: ◊ No ◊ Yes
Have you had a Slip & Fall, Trauma, Broken Bone?: ◊ No ◊ Yes
Have you had x-rays/CT Scan/MRI (Other than dental visits)?: ◊ No ◊ Yes