Miano Family Chiropractic Center, LLC

PREGNANCY 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: _____

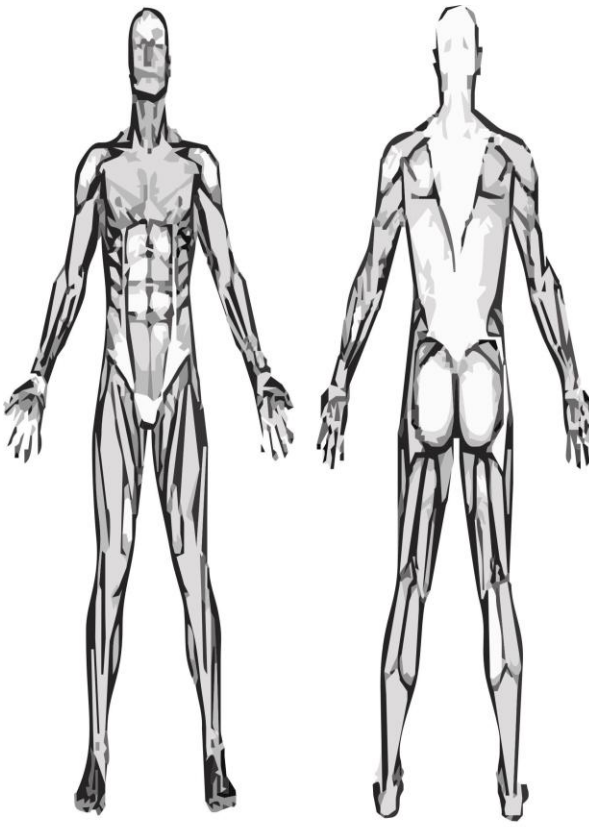
_____

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, please circle to indicate if it is:
Getting Worse Getting Better Staying the Same

Circle any/all of the listed that **BRINGS YOU 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: _____ **CASE 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: _____ _____ _____ _____ _____

Do you have any of the below listed conditions now or in the past?

MUSCULO / SKELETAL ISSUES:

Yes No Arthritis
Yes No Osteoporosis
Yes No Osteopenia
Yes No Headaches
Yes No Scoliosis
Yes No Neck Pain
Yes No Mid-Back Pain
Yes No Lower Back Pain
Yes No Shoulder/Arm/Hand Pain
Yes No Leg/Foot Pain
Yes No Paralysis
Yes No Dizziness
Yes No Numbness / Tingling
Other: _____

SYSTEMIC / NEUROLOGICAL DISEASE:

Yes No Cancer
Yes No Diabetes
Yes No Stroke
Yes No Epilepsy
Yes No Parkinson's Disease
Yes No Alzheimer's Disease
Yes No Multiple Sclerosis
Yes No Mental Health Issue
Yes No Anxiety / Depression
Yes No ADD/ADHD/ODD
Other: _____

RESPIRATORY ISSUES:

Yes No Asthma / Lung Disease
Yes No Frequent Pneumonia / Bronchitis
Yes No Seasonal Allergies
Other: _____

CARDIAC ISSUES:

Yes No Heart Disease
Yes No Chest Pain/Heart Attack
Yes No High/Low Blood Pressure
Yes No Circulatory Disease/Disorder
Other: _____

DIGESTIVE ISSUES:

Yes No Do you have a Bowel Movement daily
Yes No Allergies/Sensitivities(Food)
Yes No Poor/Excess Appetite
Yes No Excessive Thirst
Yes No Frequent Nausea/Vomiting
Yes No Heartburn
Yes No Diarrhea/Constipation
Other: _____

GENITO / URINARY ISSUES

Yes No Kidney Stones / Infection
Yes No Bladder Infection
Yes No Reproductive Problems
Yes No Yeast Infections
Other: _____

REVIEW OF SYSTEMS & INFECTIOUS DISEASE:

Yes No Tuberculosis
Yes No Influenza / Pneumonia
Yes No Vision Problems/Eye Disease
Yes No Dental Problems / TMJ
Yes No Frequent Ear Infections
Yes No Loss of Hearing/Tinitis
Yes No Loss of Smell
Yes No Fatigue / Loss of Sleep
Other: _____

Name: _____ Date: _____ **CASE 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:

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

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

Name: _____ Date: _____ CASE HISTORY (PAGE 5)

STRESS PROFILE:

Chiropractors are trained to detect and correct imbalance of the **SPINE & NERVOUS SYSTEM**.

Your **NERVOUS SYSTEM** controls and coordinates **ALL** of your bodies' sensations and functions.

There are three types of **STRESS** that will affect the **SPINE & NERVOUS SYSTEM**:
Emotional Stress, Chemical Stress, and Physical Stress.

The last page of your intake will help us to see which stresses **directly impact your present symptoms.**

EMOTIONAL STRESS:

Please indicate if you have in the past or presently experience any of the following emotional stressors:

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

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