BCM BEDDINGTON CHIROPRACTIC AND MASSAGE

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Pre/Postnatal Care Intake Form

Date: ____________________

General Patient Information

Name ____
Age _____ Date of Birth ____
Gender: Male ___ Female ___
Home Address____
City _______________________________ Province ____ Postal Code ___________________
Home phone (___) _____________ E - mail address: _________________________________
Business Phone (___) ____________________Cell Phone (___) __________________________
What is the best way to reach you? ____
Occupation: ___________________________Employer: ________________________________
Alberta Health Care number: ____
Do you have other children? Ages? ____

Please describe why you have come to Beddington Chiropractic and Massage today:
____
____
____

Previous Chiropractor? Yes ___ No ___ Name of Chiropractor: _________________________
Name of Chiropractic Clinic: ____
Date of last visit: ____________________ Health Concern: ______________________________

Name of Medical Doctor/Clinic: ____
Phone: ________________________
Date of last visit: ____________________ Health Concern: ______________________________

Have you ever injured your spine, head, neck, rib/chest area, back, pelvis or hips?
Yes ___ No ___ Where/ when: ____
____
Have you ever broken any bones or sprained any part of your body? Yes ____ No ___
Where/ when: ____
Have you ever been hospitalized or had any previous surgeries? Yes ___ No ____
Where/ when: ____
Have you had x-rays taken in the past year? Yes___ No ____
If yes, where and when: ____

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Have you ever experienced any of the following? Please indicate as;
N= normally experience
PP= experienced during a *previous pregnancy*
TP= experienced during *this pregnancy*

Allergies ____
Flu/Colds____
Heartburn ____
Carpal Tunnel ____
Constipation ____
Fatigue ____
Low Blood Pressure ____
Decreased Urination ____
Previous Heart Attack ____
Painful/irregular menstruation ____
Depression ____
Nausea/ morning sickness ____
Neck/ Low back pain ____
Breech/ side lying presentation ____

Skin Problems ____
Bloating/ gas ____
Headache/Migraine ____
Thyroid Problems ____
Asthma ____
High Blood Pressure/ pre-eclampsia ____
Increased Urination Frequently ____
Previous Stroke ____
Irritability/anger ____
Loss of Sleep ____
Birth Control Pill/Shot ____
Gestational diabetes ____
Round Ligament pain ____
Leg cramps ____

<u>Prenatal History</u>

Is this your first pregnancy? ___Yes ___No
If 'No', how many other births have you had? _________
How many weeks pregnant are you now? ____________
Estimated due date: ________________________________
Have you experienced any traumas (accidents, falls) during this pregnancy?
Yes ___ No ___ Please describe: ____
Medication taken during this pregnancy? Yes ____ No ____
If yes, which ones: _______________________________
Do you smoke or drink alcohol? Y ___ N ___
If yes, how much/how often: _________________________________
Have you had any evaluation procedures (ultrasound, amniocentesis, chorionic villus sampling)? Y ___ N ___
If yes, please list dates, frequency and reason for these procedures:
____
____
Have you employed any fertility or conception therapies/ aids? Y ___ N ___
If yes, which ones and when: ____
How has your diet been during this pregnancy?
____
____
Have there been any stressful events in your life during this pregnancy?
____

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What are your most significant fears associated with this birth?

____

Who is your birth care provider? ____

Name: _______________________________________

Will you have someone with you at birth for support (other than birth care provider)? Yes ___ No ____

Where do you plan on delivering?

____

Have you put together a birth plan? Yes ____ No ____

If yes, what might it include: ____

____

Post Natal History

Place of birth: Hospital ___ Birthing Center ___ Home ___ Other: _______________

Delivering Practitioner: OB/Gyn ___ Certified Nurse Midwife ___ Certified Midwife ___ Lay Midwife ___ Other: ______________________

Position of Delivery: Lithotomy position (on back with feet up) ___ On Your Side ___ Kneeling ___ Squatting ___ Other: _______________________________

Was labor induced? (Contractions were stimulated prior to the natural onset of labor) Yes ___ No ___ Unknown ___

If yes, specify type: Pitocin ___ Prostagland Gel (applied to your cervix) ___ Unknown ____

Were your membranes ruptured by your care provider? Yes___ No ___Unknown___

Were contractions stimulated intravenously with pitocin once labor started? Y ___ N ___ Unknown ____

Did you receive any pain medications or anesthesia? Yes ___ No ___ Unknown___

Please specify type used: _______________________________________

If you had an epidural, how many centimeters were you dilated when it was administered? _______ cm

Did you experience back pain during labor? Yes ___ No ___ Unknown___

Did you deliver vaginally? Yes ___ No ___

Baby presentation at time of delivery: Normal ___ Posterior ___ Brow ___ Facial ___ Breech ___

If breech, specify type: Footling ___ Frank ___ Complete ____ Kneeling ___

Was there any visible injury to your baby? Yes ___ No ___ Unknown___

If so, where on your baby was the injury sustained? ____________________________

Did your care provider assist delivery with his/her hands? Yes ___No ___Unknown ___

Was there any turning of the neck, or traction (pulling) applied to the neck? Yes____ No ___ Unknown _____

Were operative devices used to facilitate the birth? Yes ___ No ___ Unknown ____

Which type? Forceps ___ Vacuum ___ Extraction ___

If yes, were there any visible signs of injury to your baby? Yes ___ No ___ Unknown ____

If yes, where was the injury sustained? __________________________________

Was there a birthing coach present? Husband ___ Doula ___ Friend ___ Other ____

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If other, please specify: ______________________________

How long was your labor? ______________________________

At what week of pregnancy was your baby born? ______________________________