Family Wellness Centers

Ballston Spa / Rotterdam / Schuylerville • New York
www.aacwellness.com • www.kirokidz.com

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Pregnancy Wellness Profile

Practice Member Information _____ File _____

Name: _____
Appointment Date D _____ M _____ 20 _____ Birth Date D _____ M _____ Y _____
Home Address: _____
Home Phone: _____ May we leave a message? ☐ Yes ☐ No
Cell Phone: _____ May we leave a message? ☐ Yes ☐ No
Work Phone: _____ May we leave a message? ☐ Yes ☐ No
Email: _____
May we add you to our email newsletter and calendar of events? ☐ Yes ☐ No (Your email will not be shared)
Spouse's name? _____
Name(s) and age(s) of children: _____ _____ _____ _____
Occupation: _____
Do you primarily: ☐ Sit ☐ Stand ☐ Perform repetitive tasks
How did you hear about us? _____

Healthcare History

Have you had previous chiropractic care? ☐ No ☐ Yes
Who was your previous Chiropractor? _____
Where? _____ When? _____
Were X-rays taken in the last 6 months? ☐ Yes ☐ No
What was the primary reason for consulting that office?
☐ Relief Care - Symptom relief of pain or discomfort
☐ Corrective Care - Correcting, relieving and stabilizing spinal, joint and postural issues
☐ Wellness Care - Maximizing the body's ability for optimal healing and function
Do you feel your previous chiropractic care was effective? ☐ No ☐ Yes
Please explain: _____
Are you wearing: ☐ Heel Lifts ☐ Custom Orthotics
Family Doctor: _____
Date and reason of last visit: _____
May we contact your family doctor regarding your care at our office if necessary? ☐ No ☐ Yes
Naturopathic Doctor: _____
Date and reason of last visit: _____

Other Specialists and healthcare professionals:
Name: _____
Professional Designation: _____
Date and reason of last visit: _____
Name: _____
Professional Designation: _____
Date and reason of last visit: _____

Pregnancy Profile

How far along in your pregnancy are you?_____ When is your baby's due date? D_____M _____Y _____

Have you taken any medications during this pregnancy? ☐No ☐Yes:

OTC and Reason: _____

Prescription and Reason: _____

Vaccines and Reason: _____

Have you experienced any physical trauma during this pregnancy? ☐No ☐Yes _____

Have you had any evaluation procedures (ultrasound, amniocentesis, chorionic villus sampling)? ☐No ☐Yes

Dates and Reasons: _____

_____

_____

Have there been any stressful events in your life during this pregnancy? ☐No ☐Yes _____

_____

_____

What type of birth care provider are you planning on using? ☐Midwife ☐OB/Gyn ☐Medical Doctor ☐Other

Where do you plan on delivering? _____

Is this your first pregnancy? ☐Yes ☐No:

If not, how many pregnancies previously? _____

How many children do you have? _____

Miscarriages? ☐No ☐Yes: ☐D&C ☐Natural Miscarriage

How many vaginal deliveries? _____

How many caesarean sections? _____

Have there been any complications during your previous deliveries? ☐No ☐Yes _____

Was labor induced/use of Pitocin? ☐No ☐Yes ☐Unknown

Did your care provider rupture your membranes? ☐No ☐Yes ☐Unknown

Was there any back or hip pain during labor? ☐No ☐Yes

Was baby in a suboptimal position during the pushing phase of any labor? ☐No ☐Yes ☐Unknown

Did you receive an epidural? ☐No ☐Yes

Were there any operative devices used? ☐No ☐Yes ☐Forceps ☐Vacuum

Any postpartum complications or long term consequences? ☐No ☐Yes _____

_____

Have you experienced any of the following symptoms during this pregnancy or a previous pregnancy?

CURRENT	PREVIOUS		CURRENT	PREVIOUS	
☐	☐	Headaches	☐	☐	Carpal Tunnel (numbness in hands/fingers)
☐	☐	Facial Paralysis	☐	☐	Low/Mid Back Pain
☐	☐	Chronic Fatigue	☐	☐	Breech or Sidelying Presentation
☐	☐	Nausea/"Morning Sickness"	☐	☐	Round Ligament Pain/Pulling (front of belly)
☐	☐	Heartburn/Indigestion	☐	☐	Pain in your Pubic Bone
☐	☐	Preeclampsia	☐	☐	Pins/Needles in the Front/Side of your Leg
☐	☐	Gestational Diabetes	☐	☐	Pain in Posterior Leg (Sciatica)
☐	☐	Constipation	☐	☐	Leg Cramps
☐	☐	Hemorrhoids	☐	☐	Swelling of Ankles, Legs and Feet

Wellness Profile

Do you have a specific concern that brings you in?

☐ No, I'm interested in having my spinal and pelvic alignment assessed to help achieve optimal growth and delivery for my baby

☐ Yes: _____

If yes, please answer the following questions:

What is your primary area of complaint today? _____

How long have you been aware of this? _____days _____ weeks _____ months _____ years

Where else does this pain go in your body? _____

How often do you experience this? ☐daily ☐weekly ☐monthly ☐comes and goes ☐constantly

On a scale of 1 to 10 (10 being the worst), how does it feel when it's at its worst? _____

How would you describe the pain/discomfort?

☐Dull ☐Achy ☐Throbbing ☐Stabbing ☐Tight/Stiff ☐Burning ☐Sharp ☐Other _____

What makes it feel worse? _____

What makes it feel better? _____

Do you notice any other problems in your body when you get this pain/discomfort? _____

Do you feel your condition getting progressively worse? ☐No ☐Yes

Do you feel your condition can be healed? ☐No ☐Yes

What have you tried that ***has*** helped? ☐Ice ☐Heat ☐Medication ☐Massage ☐Physical Therapy ☐Chiropractic ☐Other _____

What have you tried that ***hasn't*** helped? ☐Ice ☐Heat ☐Medication ☐Massage ☐Physical Therapy ☐Chiropractic ☐Other _____

See additional ***Spinal Nerve Function Form*** to provide further detail on your *Wellness Profile* (***Page6***)

Lifestyle Information

The human body is designed to be healthy. The primary system in the body which coordinates health and function is the nervous system. Your nervous system is surrounded and protected by the bones of the spine, called vertebrae. Physical, emotional, and chemical stresses, common to our contemporary lifestyle, can result in misalignment to the spinal column as well as damage the delicate nervous system. The result is a condition called a ***Vertebral Subluxation.*** The remainder of the intake form addresses the possible factors which may contribute to vertebral subluxation in your spine which may be impeding your body's ability to heal.

Physical

Height _____ Weight _____

Are you happy with your current physical appearance and abilities? ☐Yes ☐No

Frequency of exercise/week: Cardio? . . . . . ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7

Weight bearing?. ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7

Do you stretch after exercise or after other activities of poor posture? ☐Yes ☐Sometimes ☐No

Hours of sleep/night? ☐<6 ☐7-9 ☐10+

Do you feel refreshed upon waking? ☐Always ☐Sometimes ☐Rarely

Age of mattress? _____ Do you feel your mattress is appropriate for your sleeping style? ☐No ☐Yes

Which position do you sleep? ☐Back ☐Belly Side: ☐Right ☐Left ☐Both

Number of hours spent commuting/week? ☐0-2 ☐3-5 ☐6-8 ☐9-11 ☐12+

Number of hours spent at a desk or computer/week? ☐0 ☐1-5 ☐6-10 ☐11-20 ☐21-40 ☐41+

Number of hours spent on smart device/tablet/week? ☐0 ☐1-5 ☐6-10 ☐11-20 ☐21-40 ☐41+

Do you perform any repetitive tasks at home or at work? ☐No ☐Yes

Have you ever been hospitalized or had surgery? ☐No ☐Yes If yes why and when? _____

_____

Have you ever been in a motor vehicle accident (even if it was minor)? ☐No ☐Yes

If yes, what kind and when? _____

Were you evaluated and treated after each accident? ☐ No ☐Yes

Have you had any non-vehicle accidents or falls? ☐No ☐Yes _____

Early Years

To your knowledge, was your delivery difficult? ☐No ☐Yes
☐If yes: ☐Forceps ☐Vacuum ☐Caesarean ☐Breech ☐Other_____
Were you breast fed? ☐No ☐Yes For how long? _____
Did you experience emotional trauma as a child? ☐No ☐Yes _____
Were you ever given antibiotics as a child? ☐No ☐Yes _____
Did you ever have ear infections as a child? ☐No ☐Yes _____
Any major childhood illness? ☐No ☐Yes _____

Emotional

Rate your current level of ***personal stress*** in your life: . . . . . ☐None ☐Low ☐Moderate ☐High
Rate your current level of ***relationship stress*** in your life: . . . . . ☐None ☐Low ☐Moderate ☐High
Rate your current level of ***financial stress*** in your life: . . . . . ☐None ☐Low ☐Moderate ☐High
Rate your current level of ***health stress*** in your life: . . . . . ☐None ☐Low ☐Moderate ☐High
Rate your current level of ***family stress*** in your life: . . . . . ☐None ☐Low ☐Moderate ☐High
Rate your current level of ***career stress*** in your life: . . . . . ☐None ☐Low ☐Moderate ☐High
Do you feel you have a supportive network of friends and family? . . . ☐Yes ☐No
Do you feel you have healthy coping strategies for life stress? . . . . . ☐Yes ☐No

Chemical

Were you vaccinated as a child? . . . . . ☐No ☐Yes
Any adverse reactions to vaccines? . . . . . ☐No ☐Yes_____
Do you choose to have annual flu shots? . . . . . ☐No ☐Yes
Do you take antibiotics? . . . . . ☐No ☐Yes, How often? _____
How many glasses of water/day:. . . . . ☐0 ☐1-3 ☐4-6 ☐7-9 ☐10+
How many glasses of caffeinated beverages/day: . . . . . ☐0 ☐1-3 ☐4-6 ☐7-9 ☐10+
How many glasses of cow's milk, juice and pop/day: . . . . . ☐0 ☐1-3 ☐4-6 ☐7-9 ☐10+
Do you eat gluten?. . . . . ☐No ☐Yes ☐Trying to eliminate from diet
Do you eat dairy? . . . . . ☐No ☐Yes ☐Trying to eliminate from diet
Do you eat refined sugars? (white sugar, white bread and pasta) . . . . . ☐No ☐Yes ☐Trying to eliminate from diet
Do you eat boxed/frozen foods?. . . . . ☐No ☐Yes ☐Trying to eliminate from diet
Do you choose organic foods?. . . . . ☐No ☐Yes, which: ☐Veggies ☐Fruits ☐Meats ☐Grains ☐All
Do you eat any artificial sweeteners? (Splenda, Aspartame, Diet Soda, etc) . ☐No ☐Yes
Any food/drink allergies, sensitivities, intolerances?. . . . . ☐No ☐Yes_____
Do you smoke? . . . . . ☐No ☐Yes ☐I used to for__ years ☐I wish I didn't
Are you or have you been exposed to second hand smoke? . . . . ☐No ☐Yes
Do you drink alcohol? . . . . . ☐No ☐Yes ☐0-6/week ☐6-12/week ☐12+/week
Do you take a probiotic daily?. . . . . ☐No ☐Yes, _____ CFU's/day
Do you take vitamin D3 daily?. . . . . ☐No ☐Yes, _____ IU's/day
Do you take Omega 3 Fish Oils daily?. . . . . ☐No ☐Yes, _____ mg/day ☐Capsule ☐Liquid
Other supplements or homeopathics? _____
Any other daily medication and their purpose? _____
_____
Do you have a plan in place with your medical doctor to wean yourself off of any long term medications? ☐No ☐Yes

Family Health

At our clinic we are not only interested in your health and wellness, but also the health and wellness of the important people in your life. Please mention below any health conditions or concerns you may have about your:

Children: _____

Spouse: _____

Mother: _____

Father: _____

Brothers/Sisters: _____

Are you seeking chiropractic care today for:

- ☐ Relief Care - Symptom relief of pain or discomfort
- ☐ Corrective Care - Correcting, relieving and stabilizing spinal, joint and postural issues
- ☐ Wellness Care - Maximizing the body's ability for optimal healing and function
- ☐ Pregancy Care: regular care throughout pregnancy to optimize the growth and development of my baby and prepare my body for a healthy delivery and fast recovery.

Do you have other concerns we should know about? _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Goals & Consent

What is your primary goal for consulting our clinic? _____

Our goals are to provide a detailed assessment of your current health status and provide to you the resources for a highly engaged and healthy body which is functioning at its absolute peak potential. Essential is a healthy nervous system functioning free from interference called subluxations. You've taken an important step for your health through a chiropractic evaluation!

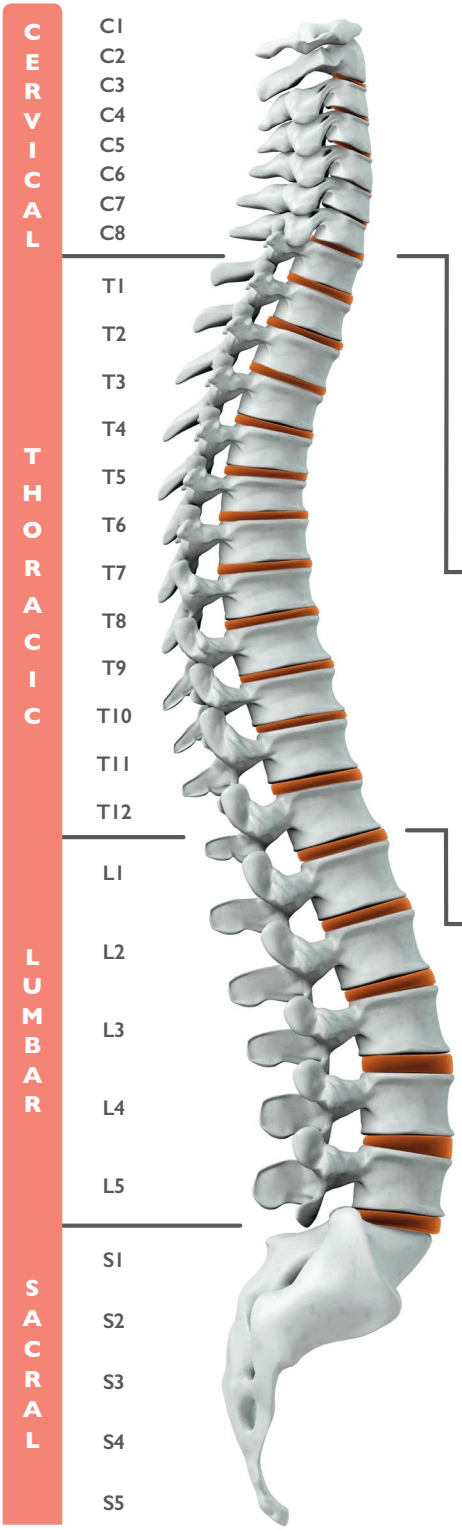
Consent to Evaluation

I _____ hereby grant permission to receive a chiropractic evaluation including history, spinal scan and examination. Any findings will be communicated before consenting to commencement of treatment, if appropriate.

_____ _____

Consenting Adult's Signature Date

SPINAL NERVE



ORGANS & GLANDS

The organs and glands listed below are linked to the corresponding sections of the spine and it's spinal nerves.

C1 C2 C3 C4 C5 C6 C7 C8
Parotid Gland • Scalp
Base of Skull • Eyes
Lacrimal Gland • Sinuses
Inner, Middle & Outer Ear
Nose • Mouth
Intracranial Blood Vessels
Sympathetic Nervous System
Neck Muscles • Diaphragm
Shoulders • Elbows • Arms
Wrists • Hands & Fingers
Tonsils • Vocal Cords
Esophagus • Heart
Lungs • Chest • Thyroid

T1 T2 T3 T4 T5 T6 T7 T8 T9 T10 T11 T12
Arms • Wrists
Esophagus • Chest • Heart
Lungs • Trachea • Larynx
Diaphragm • Stomach
Gallbladder • Liver
Pancreas • Small Intestine
Spleen • Kidneys • Appendix
Adrenals • Colon • Buttocks
Uterus • Ovaries • Testes

L1 L2 L3 L4 L5
Large Intestine • Colon
Thighs • Buttocks • Groin
Knees • Legs • Feet
Reproductive Organs

S1 S2 S3 S4 S5
Buttocks • Groin • Legs
Ankles • Feet • Toes
Prostate Gland • Bladder
Reproductive Organs

ASSOCIATED SYMPTOMS

Please indicate below any symptoms you are currently experiencing as well as any you have previously experienced.

CURRENT	PREVIOUS	
☐	☐	Sinus & Ear Pain/Infection
☐	☐	Runny Nose & Allergies
☐	☐	Frequent Head Colds
☐	☐	Sore Throat & Tonsilitis
☐	☐	Strep Throat
☐	☐	Chronic Cough & Croup
☐	☐	Difficulty Breathing
☐	☐	Poor Immunity
☐	☐	Dizziness & Vertigo
☐	☐	Tinnitus & Ear Fullness
☐	☐	Vision Problems
☐	☐	Watery/Dry Eyes
☐	☐	Chronic Fatigue
☐	☐	Poor Concentration
☐	☐	Depression
☐	☐	Asthma
☐	☐	Bronchitis & Pneumonia
☐	☐	Congestion
☐	☐	Reflux & GERD
☐	☐	Indigestion & Heartburn
☐	☐	Stomach Pains
☐	☐	Ulcers
☐	☐	Gas & Bloating
☐	☐	Jaundice
☐	☐	Liver Conditions
☐	☐	Blood Sugar Dysregulation
☐	☐	Irritable Bowel, Colitis, Crohn's
☐	☐	Gas Pain & Constipation
☐	☐	Diarrhea
☐	☐	Hemorrhoids
☐	☐	Bladder Infections
☐	☐	Bladder Incontinence & Bedwetting
☐	☐	Painful/Excessive Urination
☐	☐	Varicose Veins
☐	☐	Leg Cramping
☐	☐	Restless Legs
☐	☐	Poor Circulation & Cold Feet

CURRENT	PREVIOUS	
☐	☐	Anxiety & Stress
☐	☐	Seizures
☐	☐	ADD/ADHD
☐	☐	Thyroid Dysfunction
☐	☐	Metabolic Dysfunction
☐	☐	Insomnia
☐	☐	High/Low Blood Pressure
☐	☐	Enlarged Lymph Glands
☐	☐	Migraines & Headache
☐	☐	TMJ Pain
☐	☐	Stiff Neck
☐	☐	Arm Pain
☐	☐	Hand/Finger Numbness
☐	☐	Loss of Grip Strength
☐	☐	Kidney Stones
☐	☐	Gall Bladder Attacks
☐	☐	Skin Conditions & Rashes
☐	☐	Menstrual Cramps/PMS
☐	☐	Infertility
☐	☐	Menstrual Dysfunction
☐	☐	Rashes & Eczema
☐	☐	Hyperactivity
☐	☐	Shoulder Pain
☐	☐	Midback Pain
☐	☐	Rib Pain
☐	☐	Prostate Dysfunction & Impotence
☐	☐	Ovarian Cysts & Endometriosis
☐	☐	Fertility Problems/ Loss of Menstruation
☐	☐	Low Back Pain
☐	☐	Hip Pain
☐	☐	Thigh Pain
☐	☐	Numbness & Tingles in Legs
☐	☐	Sciatica
☐	☐	Pelvic Pain
☐	☐	Knee Pain
☐	☐	Ankle Pain & Sprains
☐	☐	Foot Pain & Weak Arches