Office Use: Date: Patient #:

NEW MOM HEALTH HISTORY

Welcome! *Please complete this form and bring it to your first appointment.*

PERSONAL INFORMATION

Name:	Date of Birth:	Age:
Address:	City:	Postal Code:
E-mail:	Mobile#:	Home#:
Occupation:	Employer:	
Marital Status:	Spouse's Name:	
Children:		

How did you hear about our office? ☐ Website ☐ Internet ☐ Location ☐ Referral:

Have you been to a chiropractor before? ☐ Yes ☐ No

Name of chiropractor:	City:
Date of last visit:	Duration and frequency of care:

Were X-rays taken? ☐ No ☐ Yes

Do you have extended health benefits that contribute to chiropractic care? ☐ No ☐ Yes

Yearly amount:	Renewal date:

Chiropractic care can be used in three ways.

We provide recommendations based on our findings to help you meet your specific health goals. Please check which you feel applies to your situation:

☐ *I just want to get rid of my pain, I'm not interested in long term correction.*

☐ *I want to get to the root of the problem and fix it for good!*

☐ *I don't have any major health concerns, and I want to keep it that way! I am here for preventive care.*

Do you foresee any barriers that will prevent you from reaching your health goals?

☐ Time ☐ Finances ☐ Other:

Please mark an "X" where you believe your health is and an "O" where you would like it to be:

Disease/ Sickness — Symptoms/ Pain — No Symptoms/ No Pain — 100% Alive/ Health

What are your health goals?

PRE-PREGNANCY

How many prior pregnancies have you had? Briefly describe previous pregnancies and deliveries:

Were there any difficulties getting pregnant? Please describe:

How was your general health prior to your pregnancy?

DURING PREGNANCY did you…

Take supplements?	☐ Yes ☐ No	Type & Reason:
Take medications?	☐ Yes ☐ No	Type & Reason:
Have an ultrasound?	☐ Yes ☐ No	Reason:

Experience any trauma? (Falls, accidents, sports injury, other)

Experience any pregnancy related complications? Please Explain:

Experience physical and/or emotional stress during pregnancy? (This includes carrying other children, repetitive motions at work, emotional stress, etc.) ☐ Yes ☐ No Describe:

YOUR MOST RECENT BIRTH

Duration of gestation(weeks):

Duration of birth(hours):

Assisted? ☐ Yes ☐ No If yes: ☐ forceps ☐ vacuum extraction ☐ C-section ☐ induced labour

Medications delivered to mother at birth? ☐ Yes ☐ No If yes, what:

Please describe your most recent birth?

POSTNATAL

Any difficulty with breastfeeding? ☐ Yes ☐ No Describe:

How are your sleep patterns? Describe:

Are you experiencing post-partem anxiety and/or depression? ☐ Yes ☐ No Describe:

Are you experiencing any changes in digestion or have you changed/restricted your diet?

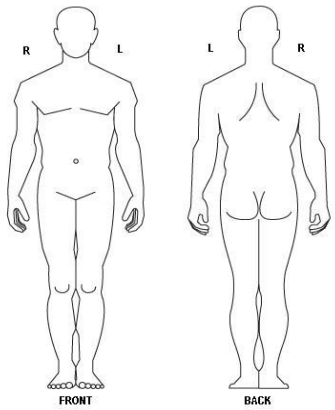
CURRENT HEALTH STATE AND SYMPTOM LOCATION

Please describe any pain or discomfort you may be experiencing below:

Pain Level 1-10, 0 = no pain, 10 = excruciating.

Feels Like examples: sharp, dull, throbbing, burning, aching, stabbing, etc.

1st Health Concern:	
When did you first notice it?	What makes it worse?
How often do you feel it?	
Getting better or worse?	
Pain Level 1-10	What makes it feel better?
What does it feel like?	
Doctor's notes:	
2nd Health Concern:	
When did you first notice it?	What makes it worse?
How often do you feel it?	
Getting better or worse?	
Pain Level 1-10	What makes it feel better?
What does it feel like?	
Doctor's notes:	



Please mark the area of your symptoms with an 'X' on the diagram:

Does this affect your work, personal life, mood, or quality of life?

□ No □ Yes - Describe:

Have you consulted any other health care providers? □ No □ Yes

If yes, list providers, diagnosis and treatments:

Please list any important family history:

Please consent to receiving reminders for appointments and important information related to your care at Arc of Life. You may opt out at any time:

Signature: _____ Date: _____