Anderson Chiropractic Group

300 Lakeshore Drive, Suite 102, Barrie, Ontario, L4N 0B4 (705) 734-9520

PREGNANCY HEALTH HISTORY FORM

Personal Information

Name: _____ Date:_____
Patient # :_____

Age: _____ Height:_____ Weight:_____ Birth date : _____
Sex: □ M □ F

Address:_____
_____

City: _____ Postal Code:_____

Phone: (H)_____ (W) _____ (C) _____

Email address: _____ □ Please add me to your email list

Who may we thank for referring you?
_____

Emergency Contact (name):_____
Phone:_____

Current Health Concern
□ If there are no current concerns and this assessment is to ensure optimum health, function and wellness tick this box.

Health Concern:
_____
__

If pain is involved, rank it on a scale of 1 to 10 (1 is minimal, 10 is extreme) 1 2 3 4 5 6 7 8 9 10

Circle or describe it's character: Sharp , dull, ache, burning, tingling, throbbing, spasm
_____
_____

When did you first notice it?
_____

What happened? _____ How often does it occur?
_____

What relieves it?_____ What aggravates it?
_____

Does it radiate or cause problems somewhere else?
_____

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Any associated or related concerns?

_____

Other professionals seen for this: _____ Treatment and results

_____

Family doctor's name: _____ Recent tests done: □ Bloodwork □ Urine □ xRays

Other Health Concerns

Please note all other health concerns present or in the past. Please tick applicable boxes.

□ Allergies □ Arthritis □ Asthma □ Blood Pressure hi/lo
□ Blood Sugar hi/lo □ Bleeding Disorder □ Cancer □ Colds (frequent)
□ Diabetes □ Digestive Disorder □ Dizziness □ Fatigue
□ Fertility Challenges □ Headaches □ Heart Disease □ Lowered Resistance
□ Menstrual Pain □ Migraines □ Multiple Sclerosis □ Numbness/Tingling
□ Osteoporosis □ Pneumonia □ Pinched Nerve □ Prostate Problem
□ Parkinson's Disease □ Seizures □ Stroke □ Thyroid Disorder

Other:

_____

About Your Pregnancy

Is this your first pregnancy? **Yes / No** If not, how many times have you been pregnant? _____

Have you had any complications with previous pregnancies? **Yes / No** (explain if yes)

_____

If you have had miscarriage(s), how far along in your pregnancy did it occur?

_____

Was this pregnancy planned? **Yes / No** What is the estimated date of delivery?

_____

Who is your primary care giver for delivery? Obgyn / GP/ Midwife? Name:

_____

What is your planned location for delivery? Home/Hospital

How do you feel about this pregnancy? _____

Have you had any testing? Genetic, blood, ultrasound, amniocentesis, chorionic villi sampling, other)?

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Dates and reasons: _____

Are you planning on breastfeeding post delivery? **Yes / No**

Was you blood pressure prior to pregnancy within normal range, low or high? _____

What is your present blood pressure and when was it last checked? _____

Have you changed your diet/menu since learning of your pregnancy? **Yes / No**

Would you like further information on healthy nutrition for pregnancy? **Yes / No**

Have you smoked prior to or along with this pregnancy? **Yes / No / Quit** _____

Have you had alcohol during this pregnancy? **Yes / No** _____

Please check any related symptoms of this pregnancy:

□ Arm or hand numbness/tingling □ Digestive complaints □ Dizziness
□ Foot pain
□ Headaches □ Heart palpitations □ Leg pain □ Low back pain
□ Nausea/vomiting □ Neck pain □ Rib or chest pain
□ Upper back pain
□ Swelling of arms □ Swelling of legs

Physical stresses

Any significant injuries, falls or traumas during infancy or childhood? **Yes No Unsure**

If yes please explain
_____

Any significant injuries, falls or traumas (car accidents) during adulthood? **Yes No Unsure**

If yes please explain
_____

Any hospital visits? **Yes No**

If yes, please explain_____

Have you had any surgeries, fractures? **Yes No**

Please explain and dates
_____

Are you in prolonged postures (ex: repetitive work, lifting, sitting, driving) **Yes No**

If yes, please explain
_____

What is your usual exercise routine?
_____

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Any fractured bones or dislocations?

_____

Any vehicle accidents? **Yes No** What happened and when?

_____

Chemical Stresses

Are you taking prescription or over-the-counter medications? **Yes / No**

If yes, please indicate what you are taking and why

_____

Are you currently taking supplements? **Yes / No**

If yes, please indicate what you are taking and why

_____

Are you exposed to pollutants, strong smells, chemicals, aerosols?

Mental/Emotional Stresses

Since psychological stress has been shown to affect numerous systems and fetal function, please let us know how you are coping with life's stresses. Rank from 1 to 10 with 1being low stress, 10 being extreme stress.

Life in general I feel _____ Work and Career I feel _____ Relationships I feel _____

Time management I feel _____ Health and well-being I feel ____ Quality of sleep I feel _____ About my pregnancy I feel _____

If you are experiencing significant or ongoing stress please explain

_____

Do you practice some form of meditation, breath work, other mind-body movement or have a routine to reduce your stress? **Yes /No**

Please explain

_____

Family Health History

Please note any health issues that are present with family members such as parents, siblings, significant other or children.

□ Cancer □ Hypertension □ Stroke □ Arthritis □ Autoimmune Disorder □ Diabetes □ Other

_____

Why Are You Here?

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People seek chiropractic care for a number of reasons and have certain expectations and perceptions. Please tick the goals which apply to you so we can accommodate your wishes.

□ Improvement in function	□ Pain reduction	□ Improved quality of life
□ Wellness	□ Relief of Symptoms	□ Healthier immune system
□ Stress reduction	□ Increased Mobility	□ Clear Brain Body Connection

□
Other:_____
_

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Anderson Chiropractic Group Informed Consent

In order for the Doctor of Chiropractic indicated below to make a determination on the suitability of my case for chiropractic care, I acknowledge and understand that I must complete a thorough chiropractic evaluation, which may include a diagnostic radiographic examination if clinically indicated. I do hereby request and consent to the performance of such an evaluation by the Chiropractor indicated below, or any party authorized to do so by that Chiropractor.
I have had the opportunity to discuss with the Doctor of Chiropractic indicated below, or with any party authorized to do so by that Chiropractor, about the nature and purpose of Chiropractic adjustments and other procedures. I understand that there are, however, some risks associated with Chiropractic care, as there are with any and all healthcare treatments. In healthcare, the matter of whether any treatment is appropriate or not is determined by looking at the level of risk and comparing this with the level of expected benefit.

I understand that in rare cases there have been incidents of injury to the vertebral artery during the course of care to the cervical spine by medical doctors, physiotherapist, and chiropractors. However, the proposed mechanism of this injury is reproduced by a wide variety of trivial neck movements such as coughing sneezing, turning your head to look out the back of a car, or having a shampoo at a hair salon. This injury is of concern because it may lead to stroke. The risk of stroke after a cervical adjustment is estimated to be approximately 1 in 1 million. To put this in perspective, studies that have assessed the risk from interventions a non-chiropractor commonly uses for the same complaints have found the following:

Risk of paralysis or stroke from surgeries or neck pain	15,600 per 1 million
Risk of death from surgery for neck pain	6,900 per 1 million
Risk of serious GI event from a NSAID (eg.Aspirin,ibuprofen)	1,000 per million
Risk of stroke following a chiropractic adjustment	1 per 1 million

To put this further into perspective, these studies estimate the risk of death before the age of 35 due to smoking cigarettes is 1677 per 1 million, and annual risk for being injured in a car accident is 13,333 per 1 million.

Another complication that may arise following a spinal adjustment is a rib fracture, muscle strain, or ligament sprain. These complications are extremely remote and the Doctor of Chiropractic is trained to assess your spine and adjust in ways that significantly diminish the risk of this occurring.

I have read and understood the risks inherent in undergoing chiropractic care, although, I do not expect the Doctor to be able to anticipate and explain all of the risks that could possibly occur. I wish to rely on the Doctor to exercise judgment during the course of chiropractic care on that basis. I have read and understood the above and I consent to all examinations and care as deemed appropriate by the Doctor of Chiropractic for my present condition, and for any future conditions for which I may seek care. I realize that I may ask any questions to the Doctor either before or after I sign this consent, and I understand that my consent can be withdrawn at any time.

ANDERSON CHIROPRACTIC DOCTORS:
DR. TOM RYAN D.C., DR. ANDREA RYAN D.C.

Name: _____ Date: _____

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Signature: _____ Witness: _____

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Anderson Chiropractic Group Fee Consent

Initial Examination

Adult	$ 99.00
Child/Student	$ 89.00

This fee includes cost of consultation, examination and report. Please allot one hour for this initial visit and thirty minutes for the report of findings

Adjustments

Adult	$ 39.00
Child/student	$ 25.00

Progress Examination & Report $20.00

Comparative Examination & Report $50.00

You are responsible for the fees incurred for each visit at the time the services are rendered. If you have extended health care coverage, please check with your insurance carrier for the particulars of your coverage. It is the policy of this office for the patient/guardian to be responsible for taking care of their account and we will provide you with an itemized statement of the services rendered. We do not bill insurers directly on your behalf. We are also happy to provide you with itemized receipts for income tax purposes.
All new complaints or injuries are assessed as per a new patient with a history and examination to ensure we have the appropriate information to assist you.

Please sign below to indicate that you have read and understood the Investment Schedule. Should you have any questions, please ask front desk staff for further information.

Signature: _____ Date: _____

E-nate Informed Consent

I provide consent to undergo treatment under the care of Dr. Tom Ryan D.C./ Dr. Andrea Ryan D.C. I understand that I will be asked to provide information about my progress throughout the treatment process, which will be added to my patient file. I am also aware that Dr. Tom Ryan D.C./ Dr. Andrea Ryan D.C. will be adding information regarding my treatment to my patient file with every clinical visit that occurs.

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It has been explained to me that the information in my patient file will be accessible by myself on an online patient file, when this feature becomes available. I understand this information will allow me to track my own progress and allow me to have an effective form of communication with my Doctor of Chiropractic. I am aware of the benefits of such a system, as it provides my Doctor of Chiropractic with more concise data with which to best manage my care, and it therefore allows for more effective tracking of my therapeutic process.

Name: _____
Date_____

Signature: _____

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