# PREGNANCY HEALTH PROFILE

"There is such a special sweetness in being able to participate in creation." ~Pamela S. Nadav

Name: Today's Date:

Home Address: City: State: Zip:

Home/Cell Phone: ( ) Work Phone: ( )

Date of Birth: Age: Sex: Male / Female Marital Status: S M P D W

Name of Partner: Names & Ages of Children:

Occupation: Employer's Name:

Email Address: Preferred Method of Communications: Email / Text / Call

Whom may we thank for referring you to our office?

Emergency Contact & Phone #:

How many weeks pregnant are you? ____wks

At what date will you be 40 wks pregnant? ________Where are you planning to give birth? __________________

What inspired you to make your appointment today with Dr. Heidi? ________________________________________

What have you loved about your pregnancy so far? ________________________________________________

_______________________________________________________________________________

What challenges have you faced during this pregnancy? ____________________________________________

_______________________________________________________________________________

Please list any concerns you have about your pregnancy/current health: __________________________

_______________________________________________________________________________

Please list any concerns you have about giving birth: ______________________________________________

_______________________________________________________________________________

Please list any concerns you have about post-partum: _____________________________________________

What would you like our help with? ____________________________________________________________

_______________________________________________________________________________

Are there any daily activities, hobbies, relationships, or work performance that this symptom(s) / concern/ condition interferes with and how so? ____________________________________________

____________________________________________

How will achieving the results you're looking for benefit you and the people closest to you? ________________

____________________________________________

What do you hope to get out of our consultation & exam today? ____________________________________________

What is your commitment level from 1-10 (10 is the highest) for self-care and the well-being and health of yourself and your baby during this pregnancy? ____________________________________________

Have you ever had your Spine and/or Nervous System evaluated professionally? **Y N**

If yes, with whom?____________________________________________

Have you ever been to a Chiropractor? **Y N**

If yes, please describe the type of technique or method he/she used and how was your experience and results?

____________________________________________

What is the name & number of your family doctor?____________________________________________

What is the name(s) & number of your OB/midwife? ____________________________________________

Date of last pregnancy consultation & result ____________________________________________

**HISTORY OF PHYSICAL STRESSES**

Were there any difficulties associated with your mother's pregnancy or your birth? **Y N**

If yes, please describe ____________________________________________

Have you had an accident or near accident, even as a passenger, in a(n): (check all that)

□Automobile □Motorcycle □Bus □Bicycle □Train □Plane □Other______________________

Explain all with dates____________________________________________

____________________________________________

What sports did you play in the past and when?____________________________________________

____________________________________________

What are your current hobbies and sports that you participate in? ____________________________________________

____________________________________________

**Medical Past & Present Interventions:** (check all that apply)

□Hospitalization □Surgery □Chemotherapy □Cast/Collars □Traction

□Organ/Body Part Removal □Extensive X-rays □Physiotherapy □Spinal Tap □Shoe Lifts

□Other____________________________________________

Explain with dates ____________________________________________

____________________________________________

**Please check all that apply & note dates of the below listed potential causes of Spine / Nervous System stress:**

**FALLS**: □From Crib________ □Tree_____ □Bicycle_____ □Steps_____ □Skates_____ □On Ice_____

□Physical Fight_____ □Armed Forces_____ □Abuse_____ □Childhood illness_____

□Broken Bones_____ □Crutch/Cane_____ □Major Dental Work_____

□Other____________________________________________

Description and Comments

____________________________________________

Have you ever been knocked unconscious? **Y N** Have you ever sustained any head injuries? **Y N**
Explain with Dates______________________________________________

Have you ever been diagnosed or treated for the following conditions? Please note the dates also.
□Cancer____ □Heart Disease____ □Diabetes____ □AIDS/HIV____ □Stroke____
□Severe Depression____ □Arthritis____ □Allergies____ □Scoliosis____ □Anxiety____
□TMJ____ □Other______________________________________________
Please explain with dates and also describe anything else not listed above________________
______________________________________________

## HISTORY OF CHEMICAL STRESSES

Have you been vaccinated? **Y N** ______________________________________________
Please list any drugs you are currently taking (prescription, over-the-counter, or recreational)
______________________________________________

**Please check all that apply & note dates of the below listed potential causes of Spine / Nervous System stress:**
Are you currently taking/taken during your pregnancy: □Prescription drugs □Over-the-Counter Drugs □Antibiotics □Other
Do you or have you ever worked with: □Chemicals □Fumes □Dust □Smoke
Do you consume: □Alcohol □Coffee/Caffeine □Tobacco □Refined Sugar □Artificial Sweeteners
Description and Comments
______________________________________________

## HISTORY OF EMOTIONAL STRESSES

**Please check all that apply & note dates of the below listed life stresses and potential causes of Spine / Nervous System stress: (Please also note their severity on a 1-5 scale; 1 is the easiest and 5 is the most difficult.)**
□Childhood____ □Loss of Loved One____ □Recreation____ □Family____ □Work____
□Stress of Illness____ □Relationships____ □Commuting____ □School____ □Financial____
□Parents divorce___ □Separation/Divorce_____ □Physical Abuse____ □Sexual Abuse____
□Moving____ □Lifestyle change_____ □Lack of Support____ □Other____
□Mental/Emotional Abuse____

Description and comments
______________________________________________
______________________________________________

**PRIOR PREGNANCIES/FERTILITY HISTORY**: *Please include a brief description as applicable.*
Did you seek medical/holistic assistance to become pregnant? ______________________________
How many times have you been pregnant? ______________________________
Have you had a previous difficult/traumatic pregnancy? ______________________________
______________________________
Have you had a previous difficult/traumatic birth? ______________________________
______________________________
If you did experience a previous difficult/traumatic birth, are you in a peaceful/resolved/healed place with it or would you like to achieve a higher level of resolve/peace?______________________________
Did you experience back labor during a previous pregnancy? ______________________________
Have you had a previous cesarean? ______________________________
If you have given birth before, how did you recover physically and emotionally after each birth? ____________
______________________________
Did you have any issues with breast-feeding with previous children? ______________________________

**CURRENT LIFESTYLE:**
Please describe your eating habits during this pregnancy (to include your water intake, fresh fruits & veggies, special cravings, etc) ______________________________
______________________________

Please list any supplements/ homeopathic remedies that you are currently taking
______________________________
______________________________

Please describe your self-care habits during your pregnancy
______________________________
______________________________

What would you like to be acknowledged for with this pregnancy? ______________________________
______________________________

**<u>CURRENT PREGNANCY SYMPTOMS</u>:** *Please check each trimester that you have/are experiencing each symptom.*

| Symptom | 1st Trimester | 2nd Trimester | 3rd Trimester |
|---|---|---|---|
| Nausea | | | |
| Fatigue | | | |
| Bloating | | | |
| Constipation | | | |
| Diarrhea | | | |
| Heartburn | | | |
| Insomnia | | | |
| Neck Pain | | | |
| Shoulder Pain | | | |
| Arm/Wrist Pain | | | |
| Upper Back Pain | | | |
| Mid-Back Pain | | | |
| Low Back Pain | | | |
| Hip Pain | | | |
| Groin/Pubic Symphsis Pain | | | |
| Round Ligament Pain | | | |
| Knee Pain | | | |
| Foot Pain | | | |
| Difficulty walking | | | |
| Jaw Pain | | | |
| Ribcage Pain | | | |
| Shortness of Breath | | | |
| Swelling | | | |
| Insomnia | | | |
| Bloody Noses | | | |
| Skin Issues | | | |
| Gestational Diabetes | | | |
| Mood Swings | | | |
| Depression | | | |
| Baby is Transverse/Breech | | | |
| Cramping | | | |
| Spotting | | | |
| Dizziness | | | |
| Headaches | | | |
| Other: | | | |
| Other: | | | |

Which are you most interested in? □Crisis and emergency care
□Acute & Wellness Care and Postpartum Recovery

What would you need to get out of working with Dr. Heidi & receiving care to make it worthwhile for you?
________________________________________________________________________________
________________________________________________________________________________

Is there anything else you wish to share which may help us to better understand you, and why you have chosen to come into this office? ________________________________________________
________________________________________________________________________________

**INFORMED CONSENT & PAYMENT**

I hereby request and consent to the performance of evaluations, diagnostic testing, chiropractic adjustments, and other Chiropractic/Rehabilitative/Healing procedures, including possible breath work, by Dr. Wroebel and any other licensed doctors of Chiropractic who work with Dr. Wroebel or cover her practice, now and in the future.

I understand that payment is expected at the time of service unless other payment arrangements have been made in advance. I also understand that if I terminate or suspend my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Signature______________________________ Today's Date_____________