POSTNATAL CHIROPRACTIC INTAKE FORM

Today's Date: _____

PERSONAL INFORMATION: **PLEASE PRINT CLEARLY**

Name (first/last): _____ Middle Initial: _____ Sex: _____

Preferred Name: _____

Date of Birth: _____ Age: _____ Sask Health Card #: _____

Address: _____ City: _____

Prov: _____ Postal Code: _____ Email: _____

Cell #: _____ Home #: _____ Work #: _____

Occupation: _____ Employer:_____

Family Doctor: _____ Parent/Guardian Name (if under 18): _____

Emergency Contact (Name & Phone Number): _____

Referred By: _____ Referred To: _____

You can opt to receive emails/texts to keep you informed of new bookings, changes to existing appointments and reminders for upcoming appointments. Please initial the communication you would like to receive:

_____ Emailed notification of new bookings/changes to appointments

_____ Emailed reminders 24 hours prior to appointments

_____ Text reminders 24 hours prior to appointments

_____ Please do not send me any emails/text messages

LATE CANCELLATION/MISSED APPOINTMENT POLICY: As a courtesy to other clients, Chiropractors, and other providers, I understand that I must give at least **24 hours' notice** for cancellations or changes to my scheduled appointment. Stonebridge Chiropractic will charge me for **missed appointments or late cancellations at the rate of the scheduled visit, billed directly to me**, and is payable prior to my next visit. SGI, WCB and other insurers do not cover the cost of missed appointments. Please help us serve you better by keeping scheduled appointments. _____ **(Initial)**

INSURANCE POLICY: I am aware that it is my responsibility to check with my insurance company and its policies regarding provider and therapist requirements before receiving treatments from any provider at Stonebridge Chiropractic. Stonebridge Chiropractic is not responsible for any treatments not covered by my insurance. **I have read, understood and agree to the above financial policies. _____ (Initial)**

Patient Signature: _____ **Date:** _____

PLEASE CONTINUE ON OTHER SIDE ⟶

CHIEF COMPLAINT:

What prompted you to book an appointment with me today?

Please describe: _____
_____
_____
_____

What was the due date and actual birth date of baby?:_____
Was the baby pre-term or over-due?:_____
Number of previous pregnancies/children?:_____
Have you had any pelvic floor rehabilitation done?:_____
Have you seen a pelvic floor physiotherapist?:_____

Type of Birth (please circle):
C-section Intact perineum First degree perineal injury Second-third degree perineal injury Episotomy

Birth Questions:

Number of stitches?:_____
Are you still bleeding?:_____
Breast or bottle-feeding?:_____
How often are you urinating?:_____
Have you had any leaks?:_____
Any pain with bowel movements?:_____
Pain with intercourse?:_____
Any areas of numbness or restrictions?:_____
Any associated muscular pain? If so where?:_____
_____

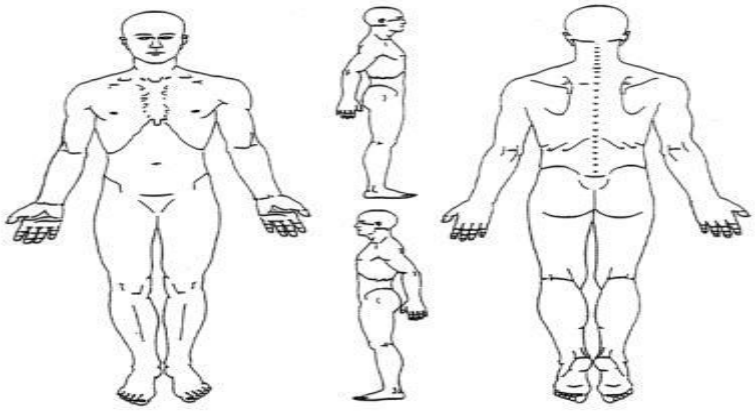
How you would describe the pain (circle):
Sharp/Stabbing Dull/Ache Pins & Needles Numbness Burning

Please circle your level of pain below:
(1 = minimal pain; 10 = worst pain)

Pain Currently
0 1 2 3 4 5 6 7 8 9 10

Pain at its Worst
0 1 2 3 4 5 6 7 8 9 10

Please mark areas of pain on the diagram below:



Is the pain constant or on/off? _____ Does the pain radiate? Yes / No Where? _____

Lately, has the pain been (circle)? getting better getting worse staying the same

Are the pain/symptoms worse in the (circle): morning night/at rest with activity

When did your condition first begin? _____

Have you had anything like this before? Yes / No When? _____

How often does the problem re-occur? _____

What makes it feel better?_____

What makes it feel worse? _____

Please list any activities you are unable to perform due to the pain, or for fear of making the pain worse:
_____

If you have seen another professional for the problem or done any self-care, describe the type of treatment AND results: _____

What else would you like the Doctor to know about you and/or your condition? _____
_____

MEDICAL INFORMATION: **PLEASE PRINT CLEARLY**

Have you had previous chiropractic care? Yes / No Dr's Name: _____ When: _____

Height: _____ Weight: _____

Last physical exam: _____ Results: _____

Are you, or might you be pregnant? Yes / No

Are you currently a smoker? Yes / No If No, did you smoke previously? Yes / No Yr. quit: _____

Have you had blood pressure/ blood clotting issues? Yes / No

Are you aware of any bone density loss? Yes / No

Please list any allergies: _____
_____

Please list any medications or supplements you take: _____
_____
_____

PLEASE CONTINUE ON OTHER SIDE ⟶

Please list any diseases, disorders, or major illnesses of biological family members. If deceased, from what? (ie: Cancer, diabetes, high blood pressure, stroke, etc.): _____

_____

_____

_____

_____

_____

_____

Please list and describe all significant previous injuries, surgeries, illnesses and hospitalizations you may have had: (sprains, fractures, accidents, etc.): _____

_____

_____

_____

Hours sitting: _____ Hours driving: _____ Hours standing: _____ Lifting: _____

How many days a week do you exercise? _____ Type of exercise: _____

How would you rate your stress level? No Stress 0 1 2 3 4 5 6 7 8 9 10 High Stress

Do you follow any diet protocol? Yes / No Please describe: _____

_____

What do you hope to do better or enjoy more when you regain your health?

_____

_____

_____

PLEASE CHECK ALL THAT APPLY:

GENERAL SYMPTOMS:
- ☐ Blackouts
- ☐ Convulsions
- ☐ Excess sweating
- ☐ Fever
- ☐ Generalized pain
- ☐ Headache
- ☐ Loss of consciousness
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Night pain
- ☐ Night Sweats

CARDIOVASCULAR:
- ☐ Angina
- ☐ Bleeding disorder
- ☐ Chest pain
- ☐ Hardening of arteries
- ☐ Heart disease
- ☐ Blood disease
- ☐ High blood pressure
- ☐ Poor circulation
- ☐ Stroke
- ☐ Swelling of ankles
- ☐ Varicose veins

SKIN:
- ☐ Shingles
- ☐ Boils
- ☐ Bruise easy
- ☐ Dryness
- ☐ Hives (allergies)
- ☐ Rashes/itching

RESPIRATORY:
- ☐ Asthma
- ☐ Chronic cough
- ☐ Difficulty breathing
- ☐ Spitting up blood
- ☐ Spitting up phlegm

MUSCLES AND JOINTS:
- ☐ Bone density loss
- ☐ Ankle/foot pain
- ☐ Arm/forearm pain
- ☐ Arthritis
- ☐ Elbow pain
- ☐ Hip pain
- ☐ Knee pain
- ☐ Loss of strength
- ☐ Low back ache
- ☐ Mid back ache
- ☐ Painful tailbone
- ☐ Shoulder pain
- ☐ Sore/stiff neck
- ☐ Wrist/hand pain

GASTROINTESTINAL:
- ☐ Belching/gas/indigestion
- ☐ Constipation
- ☐ Diabetes
- ☐ Diarrhea
- ☐ Excess hunger
- ☐ Poor appetite
- ☐ Gall bladder trouble
- ☐ Hemorrhoids (piles)
- ☐ Intestinal worms
- ☐ Jaundice
- ☐ Pain over stomach
- ☐ Ulcer
- ☐ Vomiting

GENITOURINARY:
- ☐ Bedwetting
- ☐ Blood in urine
- ☐ Kidney infection
- ☐ Prostate trouble
- ☐ Trouble urinating

GU FOR WOMEN:
- ☐ Cramping/backache
- ☐ Excessive flow
- ☐ Hot flashes
- ☐ Irregular/absent cycle
- ☐ Lump in breasts
- ☐ Painful menstruation
- ☐ Swollen breasts
- ☐ Vaginal discharge

EYES/EARS/NOSE/THROAT:
- ☐ Earache
- ☐ Enlarged glands
- ☐ Enlarged thyroid
- ☐ Eye pain
- ☐ Failing hearing
- ☐ Failing vision
- ☐ Frequent colds
- ☐ Ring/buzz in ears
- ☐ Sinus infections

NEUROLOGIC:
- ☐ Blurred vision
- ☐ Clumsiness
- ☐ Dizziness
- ☐ Double vision
- ☐ Fainting
- ☐ Nausea
- ☐ Numbness or tingling
- ☐ Problems speaking
- ☐ Problems swallowing

Patient Signature: _____ Date: _____