lifelogic
health center, llc
chiropractic, pediatrics, nutrition

Patient Intake for Expectant Moms

**Please do your best to fill out everything on this intake form. It is important that we understand past and current stressors that may have affected and could possibly continue to affect your overall health. It is important for us to know the following information, even if you feel it does not apply to the reason you came in for care. Please know that we value your time and aim only to provide you the best care possible. Thank you for choosing LifeLogic Health Center!*

Date: _____ Referred By: _____

Full Name: _____ Preferred Name:_____

Address: _____ City: _____

State:_____ Zip:_____ Social Security #: _____-_____-_____ Sex: M / F

Phone: Home: (_____) _____-_____ Cell: (_____) _____-_____

Date of Birth: _____/_____/_____ Age: _____ Email: _____

Height: _____ ft _____ in; Weight: _____ lbs (pre-preg); Weight gain during pregnancy: _____lbs

Occupation: _____ Employer: _____ Length of Employment: _____

Do you enjoy your job? Y / N Explain: _____

Duties/ Habits: _____ sit more than 1 hour _____ carry equipment/tools on your body (i.e. utility belt or child)
_____ repetitively bend or twist _____ cradle the phone shoulder to ear (which side? L or R)
_____ repetitively type _____ drive on the job (car or other) _____ lift more than 10 lbs repetitively (including child)

Marital Status: ❑ Single ❑ In a Relationship ❑ Married / Life Partner
❑ Divorced ❑ Widowed Significant Other's Name: _____

Emergency Contact: _____ Phone: (_____) _____-_____

Due Date: _____ / _____ / _____ # weeks:_____ OB/GYN: _____

Midwife: _____ Doula: _____

Are you planning a: ❑ Home Birth ❑ Birth Center Birth ❑ Hospital Birth ❑ C-Section ❑ VBAC

Have you ever received chiropractic care before? Y / N If yes, please list names and dates below:

1.Name: _____ Dates: _____

2.Name: _____ Dates: _____

Have you been to a medical doctor (besides OB/GYN) in the past year? Y / N
If yes, please list names and reasons below:

1.Name: _____ Reason: _____ for visit

2.Name: _____ Reason: _____ for visit

3.Name: _____ Reason: _____ for visit

How would you rate your health overall? (Please circle one)

(Poor) 1 2 3 4 5 6 7 8 9 10 (Excellent)

Please list the top 3 things you would like to change about your health:

1. _____ 2. _____ 3. _____

List *ALL* medications you take (prescriptions and over-the-counter- use back of page if necessary)

Drug name:	Dosage:	How long have you taken this and for what condition?
_____	_____	_____
_____	_____	_____
_____	_____	_____

List *ALL* nutritional supplements you take. (Use back of page if necessary)

Supplement name:	Dosage:	How long have you taken this and for what condition?
_____	_____	_____
_____	_____	_____
_____	_____	_____

List *ALL* previous hospitalizations, surgeries (include oral, appendix, c-section, etc.), fractures, accidents, illnesses. (Use back of page if necessary)

1. Issue_____ When _____ Hospitalized? Y / N

2. Issue_____ When _____ Hospitalized? Y / N

3. Issue_____ When _____ Hospitalized? Y / N

Past medical diagnosis / condition: (Use back page if necessary)

1. What: _____ When: _____ Diagnosed by: _____

2. What: _____ When: _____ Diagnosed by: _____

Have you experienced any <u>unexplained or rapid</u> weight changes in the last six months not related to pregnancy?

Y / N _____ lbs

On average, how many times per year do you get sick? _____ **How long does it last?**_____

Do you get sick seasonally or during the same time each year? Y / N **When?**_____

Do you have allergies? Y / N **If yes, are they seasonal, pets, pollen, etc?** _____

Do you have any known food allergies? Y / N **Please list:**_____

Do you consume the following? (Please mark "N/A" if it does not apply)

Tobacco products (packs/day) _____ # of years? _____ Alcohol (drinks/day) _____ # of years? _____

Coffee/Espresso (cups/day) _____ Reg or decaf? _____ Soft drinks (#/day) _____ Reg or diet? _____

Tea (cups/day) _____ Type (herbal, black, green, etc.) _____ Amount of water/day _____ oz.

Do you use artificial sweeteners? Y / N If yes, please list: _____

Other drinks and amount/day (juice, milk, etc.) _____ Energy drinks? Y / N

Level of exercise: None ; Light: _____ days/week; Moderate: _____ days/week; Strenuous: _____ days/week

Do you currently have or have you experienced ANY of the following within in the past 2 years? Put "P" for past and "N" for now.

____ Pubic Pain	____ Frequent infections	___ Respiratory disease
____ Sinus problems	____ Heart Disease	___ Hardening of arteries
____ Allergies	____ Asthma	___ Numbness/Tingling
____ Cold hands	____ Cold feet	___ High cholesterol
____ Stroke	____ Nervous disorder	___ Digestive problems
____ Cancer	____ Menstrual problems/ pain	___ HIV or AIDS
____ High blood pressure	____ Low blood pressure	___ Headaches (____x/_____)
____ Fatigue	____ Stress difficulty	___ Surgery
____ Diabetes (Type:_____)	____ Arthritis (OA or RA?)	___ Jaw trouble/TMJ issues
____ Changes in bowel/bladder habits	____ Concussion /Head injury	___ Neurological issues
____ Difficulty Conceiving	____ Fertility Treatments	___ Miscarriage (#wks _____)

List your #1 health concern or reason for visit: _____

Rate the severity of issue: (mild) 1 2 3 4 5 6 7 8 9 10 (extreme)

When did this first begin? _____ **Date of most recent flare-up**: _____

Have you seen anyone for this issue? Y / N **Whom?** _____ **When?** _____

What was the treatment or advice? _____

What was the result? Did it seem to work? _____

What aggravates this condition? _____

What makes it better? _____

Is it worse at certain times of the day, week or month? Y / N **When?** _____

Is it getting progressively worse? Y / N **Do you get flare-ups?** Y / N **How often?** _____

Have you had this or something similar in the past? Y / N **When?**_____

What treatment did you receive at that time? _____

Please check any of the following activities that your reason for care *interferes* with:

❑ Personal Care ❑ Lifting ❑ Bending ❑ Pushing ❑ Pulling ❑ Walking ❑ Reading ❑ Driving ❑ Standing
❑ Sleeping ❑ Hobbies ❑ Sports ❑ Work ❑ Concentrating ❑ Family/Home Responsibilities ❑ Eating/Breathing
❑ Socializing ❑ Going to the Bathroom ❑ Sexual Interactions ❑ School ❑ Being Healthy

Past & Current Pregnancy History:
How many children do you have? _____ Please list their names and ages: _____

_____

	Pregnancy #1	Pregnancy #2	Pregnancy #3	Pregnancy #4	Pregnancy #5
Morning Sickness	❑	❑	❑	❑	❑
Good Health Habits	❑	❑	❑	❑	❑
Poor Health Habits	❑	❑	❑	❑	❑
Exercise During Preg	❑	❑	❑	❑	❑
Baby Position Issues	❑	❑	❑	❑	❑
Back Pain	❑	❑	❑	❑	❑
Pubic Symphysis Pain	❑	❑	❑	❑	❑
Hours of Labor	_____	_____	_____	_____	_____
#weeks born	_____	_____	_____	_____	_____
Home birth	❑	❑	❑	❑	❑
Vaginal	❑	❑	❑	❑	❑
C-Section	❑	❑	❑	❑	❑
- Elected	❑	❑	❑	❑	❑
- Emergency	❑	❑	❑	❑	❑
VBAC		❑	❑	❑	❑
Forceps	❑	❑	❑	❑	❑
Vacuum Extract	❑	❑	❑	❑	❑
Traumatic Birth	❑	❑	❑	❑	❑
Tearing	❑	❑	❑	❑	❑
Breastfed	❑	❑	❑	❑	❑
-Until _____ mos	_____	_____	_____	_____	_____
Mastitis	❑	❑	❑	❑	❑
Formula fed	❑	❑	❑	❑	❑
-Until _____ mos	_____	_____	_____	_____	_____
Trouble feeding from L / R side	L / R	L / R	L / R	L / R	L / R

Is there anything else which may help us understand you, your history, or your needs which have not been covered in this intake? Please explain: _____

_____

_____

Remember, health is a process. Past and present choices affect this process. Thank you for taking the time to provide us with the information we need to best help you achieve your health goals. Congratulations on taking an active step toward health and thank you for giving us the opportunity to participate in this process!

Legal Agreements

I agree that a photocopy or facsimile of any document I sign for LifeLogic Health Center, LLC will be deemed as valid and binding on all parties involved as if the photocopy was the original document I sign.

Signature: _____ Date: _____

With my signature, I verify that I have gone to the U.S. Department of Health & Human Services website at **http://www.hhs.gov/ocr/privacy/** to review my health information privacy rights. I understand that I can ask the doctors in the office if I have any questions regarding my HIPAA rights.

Signature: _____ Date: _____

Accuracy of Information

With my signature, I attest that all of the information on this form is accurate and that I am over the age of 18 years. If this information is pertaining to a patient under the age of 18, I am a legal guardian or parent of the aforementioned individual.

Signature: _____ Date: _____