BODY OF LIGHT FAMILY CHIROPRACTIC
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To ensure a safer easier birth for the mother and baby, chiropractic care is essential. More and more birth practitioners are recommending that their mothers receive chiropractic care throughout pregnancy.

Pregnancy Health History

GENERAL INFORMATION:

Full Name: _____ Age: _____ DOB: _____

Home/Cell#: _____Work #: _____E-mail: _____

Home Address: _____ City: _____ State: ____ Zip: _____

Employer:_____

Marital Status: S M D W Name of Spouse: _____

Have you ever received chiropractic care? Yes No With whom? _____

Names of children: _____

Have your children received chiropractic care? Yes No With whom? _____

Emergency Contact: _____ Phone #: _____

Whom may we thank for referring you? _____

Our Chiropractic Principles/Foundation:

- The body is self-healing and self-regulating.
- The nervous system controls the body's ability to function and adapt (heal and regulate).
- Spinal misalignments (vertebral subluxations) cause interference to the nervous system.
- Chiropractors locate and correct vertebral subluxations with specific spinal adjustments.
- Adjustments remove pressure from the nervous system and allow the body to heal.

"If left alone in labor, the body of a woman produces most easily the baby that is not interfered with... If left alone, just courage and patience are required."

~ Grantly Dick-Read, Childbirth without Fear: The Principles and Practice of Natural Childbirth

Prenatal history:

Is this your first pregnancy? Yes No _____

How many other births have you had? _____

How many weeks pregnant are you now? _____

Have you experienced any traumas during this pregnancy? Yes No

_____

Have you taken medications during this pregnancy? Yes No
If yes, please describe: _____

Do you smoke or drink alcohol? Yes No Explain: _____

Have you had any evaluation procedures
(ultrasound, amniocentesis, chorionic villus sampling)? Yes No
If yes, please list:

_____

How has your diet been during this pregnancy? _____

Have there been any stressful events
in your life during this pregnancy? Yes No Explain:

_____

What, if any, are your most significant fears associated with this birth?

_____

Who is your birth care provider?

_____

Will you have someone with you at birth for support
(other than birth care provider)? Yes No Explain:

_____

Where do you plan on delivering?

_____

Have you put together a birth plan? Yes No

Previous Birth History (if applicable):

Place of birth**:** ____ Home ____ Birthing center ____ Hospital
Delivering Practitioner**:** ____ Lay Midwife ____ Nurse Midwife ____ OB/Gyn
Position of Delivery: ____ Squatting ____ Lithotomy position (on back with feet up)
____ On Your Side ____ Kneeling Other _____

Was labor induced/Pitocin? Yes No Unknown
Did your care provider rupture your membranes? Yes No Unknown

Were contractions stimulated intravenously with pitocin *after* labor started?
Yes No Unknown

Did you receive any pain medications or anesthesia? Yes No Unknown
If yes, please specify type used_____

Did you receive an epidural? Yes No Unknown
Did you experience back pain during labor? Yes No Unknown
Did you deliver vaginally? Yes No _____

Baby presentation at time of delivery: ____ Normal ____ Posterior____ Brow
____ Facial ____ Breech

If breech, specify type: ____Footling ____ Frank ____ Complete ____Kneeling

Did your care provider assist delivery with his/her hands? Yes No Unknown
Was there any turning of the neck, or traction (pulling)
applied to the neck? Yes No Unknown

Were operative devices used to facilitate the birth? Yes No Unknown
If yes, which type? ____ Forcep ____ Vacuum Extraction

Was there any visible injury to your baby? Yes No Unknown
If so, where on your baby was the injury sustained? _____

Was there a birthing coach present? ____ Husband____ Doula ____Friend Other _____
At what week of pregnancy was your baby born?
_____

Present State of Health (Presenting Symptoms). Most pregnant women visit our office to give themselves and their baby the best opportunity to have a natural vaginal birth. However, some women also experience symptoms during their pregnancy. If you have a specific concern please complete the following section:

Present complaint: _____

How long have you been suffering with this problem? _____

Describe symptom (sharp/dull/numb etc.) _____

Is the symptom: getting better staying the same getting worse

Aggravated by? _____

Helped by? _____

Is the condition worse at a specific time of day? _____

How does the symptom(s) interfere with your life? (ie: sleep/work/play/lifting children etc.)
_____

Have you seen other doctors for this condition(s)? _____

Results? _____

Financial Information: Payment in full is expected on all FIRST VISIT services. All other fees are to be paid at the time of service unless other arrangements have been made and agreed upon in writing.

Name of Insurance Company: _____
ID# / Policy #: _____

Authorization for exam (care) / Billing Insurance:

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate.

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered. I also understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself.

Signature: _____ Date: _____

Thank you for choosing Body of Light Family Chiropractic.
It is an honor for us to serve you during this magical and wonderful process.