



**Welcome! It is our pleasure to welcome you to Balance Family Chiropractic. To help us serve you better, please complete the following information. Please note, there are 2 PAGES to this form!! We look forward to working with you to build better health for you and your family.**

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_  
Postal Code: \_\_\_\_\_ Email: \_\_\_\_\_  
Home phone #: \_\_\_\_\_ Work phone #: \_\_\_\_\_  
Birth date: \_\_\_\_\_ Occupation: \_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_

What is the **main** reason for consulting our office today?

\_\_\_\_\_

Have you had previous chiropractic care? Yes \_\_\_\_\_ No \_\_\_\_\_

If so, name of previous chiropractor: \_\_\_\_\_

Date of Last visit: \_\_\_\_\_

Who are your chosen birth attendants?

Midwife \_\_\_\_\_ Obstetrician \_\_\_\_\_ Doula \_\_\_\_\_ Chiropractor \_\_\_\_\_

Name of Birth Attendants: \_\_\_\_\_

Date of Last visit: \_\_\_\_\_

Chosen Location of Birth: Hospital \_\_\_\_\_ Birthing Centre \_\_\_\_\_ Home \_\_\_\_\_ Other \_\_\_\_\_

**Chiropractors work to create balance within the nervous system so that the mother and baby can have the best possible pregnancy. Different stressors create interference to the way that the nervous system is working. These include physical (ie. Posture, falls, accidents, ect), emotional (ie. Finances, divorce, relationships, ect) and chemical stressors (ie. Over the counter medications, prescription medications, vaccines, alcohol, drugs, poor diet, ect.)**

What type of physical stressors have you experienced? \_\_\_\_\_

\_\_\_\_\_

What type of emotional stressors have you experienced? \_\_\_\_\_

\_\_\_\_\_

What type of chemical stressors have you experienced? \_\_\_\_\_

\_\_\_\_\_

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How do you grade your physical health?

Excellent \_\_\_ Good \_\_\_ Fair \_\_\_ Poor \_\_\_ Getting Better \_\_\_ Getting Worse \_\_\_

How do you grade your emotional health?

Excellent \_\_\_ Good \_\_\_ Fair \_\_\_ Poor \_\_\_ Getting Better \_\_\_ Getting Worse \_\_\_

How do you rate your occupational stress (1-10 with 10 being most stressful?) \_\_\_\_\_

Planned maternity leave? \_\_\_\_\_ If so, starting when? \_\_\_\_\_

How active is your baby?

Can't feel baby move at all \_\_\_ slow but moving \_\_\_ active \_\_\_ very active \_\_\_

Medical Testing:

Have you chosen to have an ultrasound done?

No \_\_\_ Yes \_\_\_ Number of Ultrasounds done \_\_\_ dates: \_\_\_\_\_

Amniocentesis? No \_\_\_ Yes \_\_\_ Date Performed: \_\_\_\_\_

Chorionic Villus Sampling? No \_\_\_ Yes \_\_\_ Date Performed: \_\_\_\_\_

Doppler Ultrasound? No \_\_\_ Yes \_\_\_ Date Performed: \_\_\_\_\_

Electronic Fetal Monitoring? No \_\_\_ Yes \_\_\_ Date Performed: \_\_\_\_\_

Planned C-Section? No \_\_\_ Yes \_\_\_ Reason: \_\_\_\_\_

Planned Induction? No \_\_\_ Yes \_\_\_ Reason: \_\_\_\_\_

How much weight have you gained to this point? \_\_\_\_\_

If you have had a previous pregnancy did you have or experience any of the following with your labour:

Hospital Birth \_\_\_\_\_ Home Birth \_\_\_\_\_ Birthing Centre Birth \_\_\_\_\_

Other Birth Location \_\_\_\_\_

Epidural \_\_\_ Episiotomy \_\_\_ Induction \_\_\_ Breech Presentation \_\_\_ Back Labour \_\_\_

Forceps \_\_\_ C-Section \_\_\_ Vacuum Extraction \_\_\_ Fetal scalp monitoring \_\_\_

Other intervention \_\_\_\_\_

During the day I: Sit \_\_\_ Stand \_\_\_ walk \_\_\_ do desk work \_\_\_

On the phone often \_\_\_ Drive \_\_\_ Do Mechanical Work \_\_\_ heavy lifting \_\_\_

How would you describe your:

Diet: Poor \_\_\_ Good \_\_\_ Excellent \_\_\_

Sleep: Poor \_\_\_ Good \_\_\_ Excellent \_\_\_

Exercise: Poor \_\_\_ Good \_\_\_ Excellent \_\_\_

I Exercise: \_\_\_\_\_ times a week

Were you, or are you, active in any particular sport (s)? Yes \_\_\_ No \_\_\_

Which ones? \_\_\_\_\_

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List all falls, accidents or injuries you have had and give approximate dates:

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Have you ever been hospitalized? **Y or N** if yes, when? \_\_\_\_\_

Have you ever had x-rays done? **Y or N** if yes, when? \_\_\_\_\_

Please list the 3 most **stressful** events in your life:

1) \_\_\_\_\_ date: \_\_\_\_\_

2) \_\_\_\_\_ date: \_\_\_\_\_

3) \_\_\_\_\_ date: \_\_\_\_\_

Are any of these situations continuing to impact your life? \_\_\_\_\_

When is the last time you felt at your best? \_\_\_\_\_

How many hours of sleep do you get per night? \_\_\_\_\_ Do you use 1 or 2 pillows? \_\_\_\_\_

Please **circle** any of the following that are affecting your health:

Gas or bloating after meals	visual problems	forgetfulness
Constipation	ear aches	nervousness
Diarrhea	fatigue	numbness
Nausea	loss of sleep	shortness of breath
Excessive thirst	allergies	
Poor/excessive appetite	irregular heart beat	
Weight trouble	dizziness	

Is there anything we need to know before we begin your chiropractic care? \_\_\_\_\_

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I give my consent for Dr. Jennifer Murray or her designate to perform a full and comprehensive examination on me which may include case history, thermal scan, posture analysis, x-ray and/or hands on chiropractic spinal exam.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date