BALANCE FAMILY CHIROPRACTIC

Dr. Jennifer Murray
102-12840 Yonge Street, Oak Ridges, ON L4E-4H1 905.773.5165

Welcome to Balance Family Chiropractic. To help us serve you better, please provide us with the following information. Please note, there are 2 PAGES to this form!! We look forward to working with you.

Name: ____ Date: ________________
Address: ______________________________ City: ____________________________
Postal Code: ______________ Email: _______________________________________
Home phone #: ____________________ Work phone #: _______________________
Birth date: _______________________ Gender: Female Male
Occupation: _________________________

Who may we thank for referring you? _______________________________________

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

1st Pregancy? Yes ____ No ____
If No, how many previous pregnancies? _____________________________________
Have you had previous chiropractic care? Yes ______ No _______
When pregnant? 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 _____

Different stressors create interference in the nervous system. These stressors can include physical (Posture, falls, etc), emotional (Finances, relationships, etc) and chemical stressors (medication, poor diet, etc.)

What type of physical stressors have you experienced? ___________________________
____

What type of emotional stressors have you experienced? __________________________
____

What type of chemical stressors have you experienced? __________________________
____

How do you grade your physical health?
Excellent ___ Good___ Fair____ Poor ___ Getting Better ____ Getting Worse _____

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PATIENT NAME: ____

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 maturity 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: ________________________
Doppler Ultrasound? 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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PATIENT NAME: ____

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

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? ___________
____

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 as well as a hands on chiropractic spinal exam. I clearly understand and agree that I am personally responsible for payment of all fees charged by Balance Family Chiropractic. I understand that my personal information will be kept confidential in accordance with the privacy legislation.

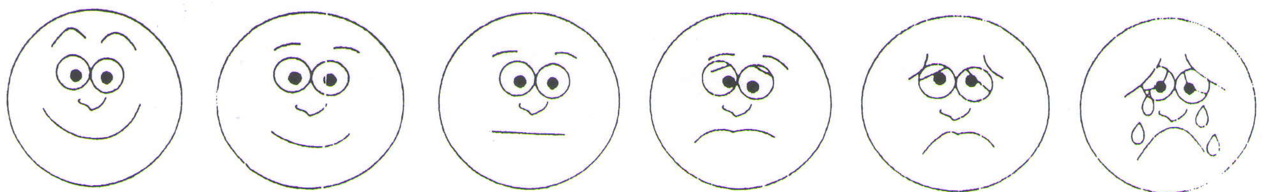
_________________________________ _________________________

Patient Signature Date

Faces and Visual Analog Pain Scales

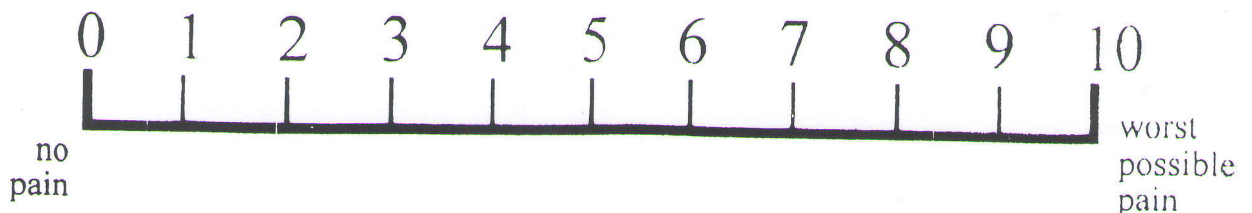
Please circle the number and/or the face that best refers to your level of pain (or lack thereof!) today. Please sign and date.

Faces Pain Scale



0	2	4	6	8	10
Very happy, no hurt	Hurts just a little bit	Hurts a little more	Hurts even more	Hurts a whole lot	Hurts as much as you can imagine (don't have to be crying to feel this much pain)

Visual Analog Scale (VAS)



Date: ______________________________

Signature: ______________________________