

PRENATAL APPLICATION

Welcome to our Practice! Please thoroughly complete all questions. Thank you.

Name: _____ Today's Date: _____

Address: _____

City/State _____ Zip: _____ E-Mail: _____

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

Marital Status: M W D S (circle one) Birth Date: ____/____/____ Age: _____

How did you hear about our office? _____

Prenatal History:

Estimated Due Date: ____/____/____ # of weeks currently pregnant: ____ weeks

of previous pregnancies ____ # of vaginal deliveries ____ # of c-sections ____ # of miscarriages ____

Reason for visit:

In utero constraint

Backache of pregnancy

Wellness

Headache

Chronic Condition

Other: _____

Use of infertility Drugs?

Yes No

If Yes:

Date started: ____/____/____

of rounds: ____

In-Vetro Fertilization?

Yes No

If Yes:

Date started: ____/____/____

of rounds: ____

Morning Sickness?

Yes No

If Yes: Week started: ____ Week ended: ____ Mild Moderate Severe

Was medication used? Yes No Type: _____

Did you receive the Flu Shot? Yes No Date of last injection: ____/____/____

Please tell us about any complications/health problems (if any), you experienced in previous pregnancy:

What birth class have you planned to take/have taken?

Bradley

Hypno-babies

None

Where: Hospital

Birthing Center

Self Study

Where do you plan to give Birth?

Home Birthing Center Hospital

If hospital: Carilion Lewis Gale Other: _____

If birthing center: _____

Do you plan to use an OBGYN Midwife NAME: _____

Do you plan to use a Doula? Yes No NAME: _____

Are you taking any supplements and/or vitamins? Yes No

If yes, which product(s)? _____

What are your expectations for your birth? (check all that apply)

No epidural Epidural only if necessary Epidural

Vaginal Delivery Scheduled C-Section VBAC

Unsure Other: _____

Health History:

Age of last menstrual cycle ____ Length of regular menstrual cycle ____

Date of last menstrual cycle ____/____/____

Are your cycles regular? Always Most of the time Never

Have you ever used birth control? Yes No If yes please check all that apply:

Oral Patch Injection Other: _____

Age first prescribed: _____ Length of time used: _____

Have you used an IUD? Yes No If yes, date removed? ____/____/____

Lifestyle Information:

Do you exercise? Yes No If yes, how much & how often? _____

Do you drink soft drinks? Yes No If yes, how much? _____

Do you drink water? Yes No If yes, how much? _____

Do you drink coffee? Yes No If yes, how much? _____

Do you smoke? Yes No If no, did you ever smoke? Yes No

If yes to either, for how long? _____

Do you drink alcohol? Previously Currently None

Social (fewer than 2 drinks a day) Heavy (More than 2 daily)

How would you rate your nutritional habits? **Great** **Good** **Fair** **Poor**

Do you take any vitamins/supplements? Yes No If yes, what kind? _____

How many hours of sleep do you usually get? _____ hours

Is the quality of sleep: **Great** **Good** **Fair** **Poor**

Stress Level (personal): **Low** **Medium** **High**

Stress Level (work): **Low** **Medium** **High**

What do you do to relieve or handle your stress?

Please check all of the following health concerns you have experienced, even if you do not think that your answers relate to your present health concern(s).

| | | | | |
|--|--|---------------------------|--|---------------|
| Allergies: Seasonal | Yes <input type="checkbox"/> No <input type="checkbox"/> | Medication | Yes <input type="checkbox"/> No <input type="checkbox"/> | If yes: _____ |
| Anxiety | Yes <input type="checkbox"/> No <input type="checkbox"/> | Hypertension | Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| Arthritis | Yes <input type="checkbox"/> No <input type="checkbox"/> | Hypotension | Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| Asthma | Yes <input type="checkbox"/> No <input type="checkbox"/> | Hypoglycemia | Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| Back Pain | Yes <input type="checkbox"/> No <input type="checkbox"/> | Immune System Disorder | Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| Bladder Problems | Yes <input type="checkbox"/> No <input type="checkbox"/> | Infertility | Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| Cancer: _____ | Yes <input type="checkbox"/> No <input type="checkbox"/> | Kidney Disease | Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| Circulatory/Vascular Disorder | Yes <input type="checkbox"/> No <input type="checkbox"/> | Menstrual Cramps/Problems | Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| Depression | Yes <input type="checkbox"/> No <input type="checkbox"/> | Mood Swings | Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| Diabetes Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | Neck Pain | Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| Date of onset: ____/____/____ | | Numbness/Tingling | Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| Diarrhea/Constipation | Yes <input type="checkbox"/> No <input type="checkbox"/> | Osteoporosis | Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| Digestive Problems | Yes <input type="checkbox"/> No <input type="checkbox"/> | Sinus Trouble | Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| Dizziness | Yes <input type="checkbox"/> No <input type="checkbox"/> | Skin Conditions | Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| Headaches | Yes <input type="checkbox"/> No <input type="checkbox"/> | Sleep Challenges | Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| Heartburn/Reflux | Yes <input type="checkbox"/> No <input type="checkbox"/> | Urinary Difficulty | Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| Heart/Cardiovascular Condition | Yes <input type="checkbox"/> No <input type="checkbox"/> | Vertigo | Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| Fractures | Yes <input type="checkbox"/> No <input type="checkbox"/> | If yes where: _____ | | |
| Surgeries | Yes <input type="checkbox"/> No <input type="checkbox"/> | Describe: _____ | | |
| Other _____ | | | | |

Medications:

Please list **ALL** medications, **DOSAGE** and **FREQUENCY** information.

- Pain Medication (over the counter/prescription) _____
- Birth Control _____
- Heart Medication _____
- Cholesterol Medication _____
- Antidepressant/ Anti-Anxiety Medication _____
- Recreation Drugs _____
- Anti-Inflammatory Medication _____
- Muscle Relaxers _____
- Aspirin _____
- Blood Pressure Medication _____
- Diabetes Medication _____
- Other _____



The above information is true and accurate to the best of my knowledge. My reason for consultation with the doctor is for evaluation of my physical health and the potential for improvement.

Patient or Guardian Signature: _____ **Date:** ____ / ____ / ____

SYMPTOM DIAGRAM

Name _____ Number _____ Date _____

Please be sure to fill this form out extremely accurately. Mark the area(s) on your body where you feel the described sensation(s). Use the appropriate symbol(s). Mark areas of radiating pain, and include all affected areas. You may draw on the face as well.

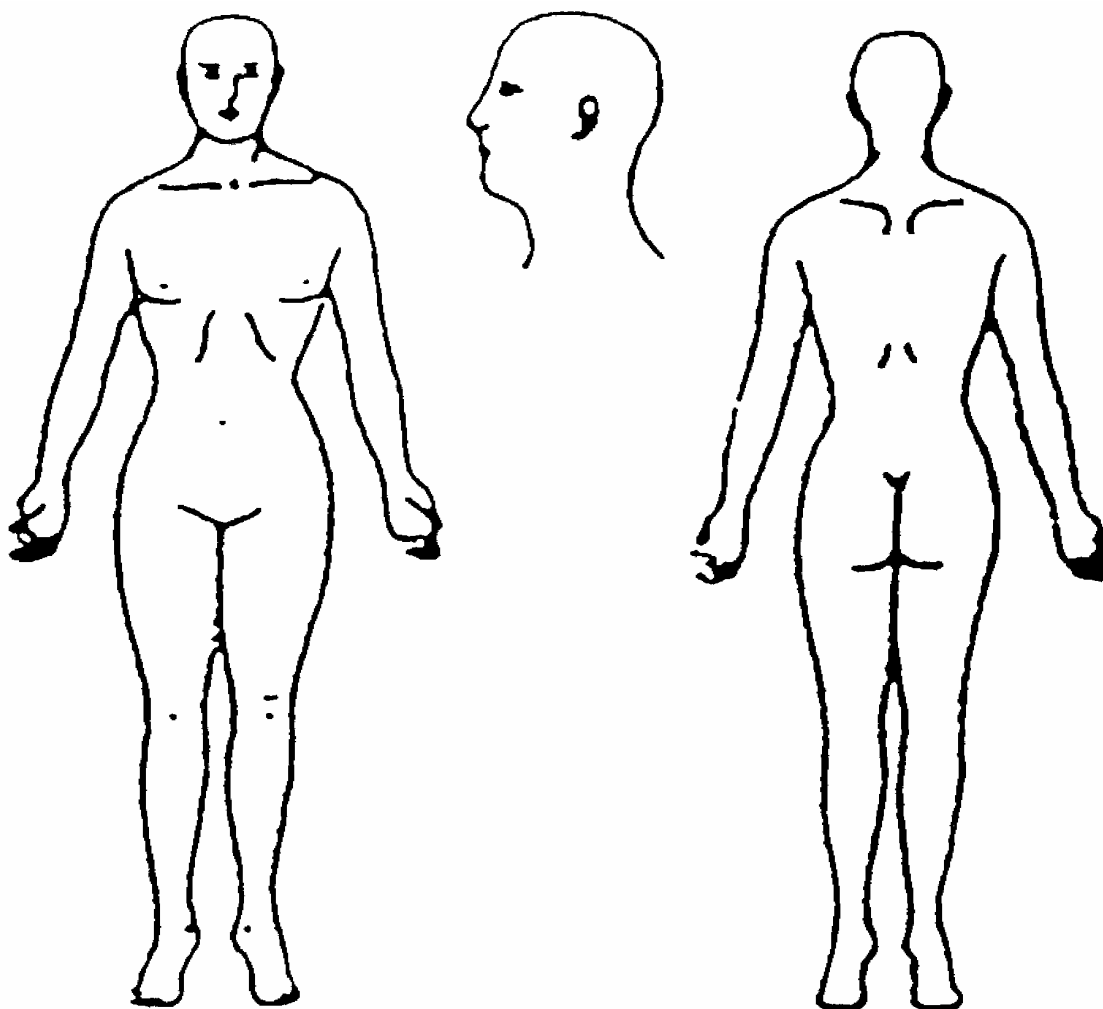
Aches $\wedge\wedge\wedge$

Numbness oooo

Pins/Needles ●●●●

Burning xxxx

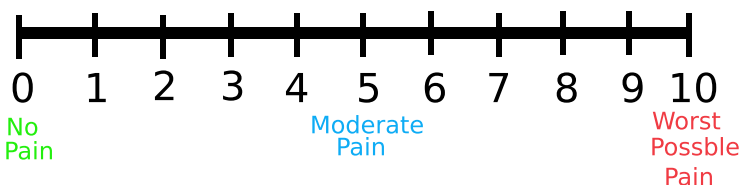
Stabbing ///



VAS

Please rate your pain level:

0-10 Numeric Pain Rating Scale



MY PAIN IS:

Acute (new)
 Chronic (old)

Daily
 Weekly
 Monthly

Other _____

This questionnaire has been designed to give us information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the one box that applies to you.

Section 1 : Pain Intensity

- I have no pain at this moment
- The pain is very mild at the moment
- The pain is moderate at the moment
- The pain is fairly severe at the moment
- The pain is very severe at the moment
- The pain is the worst imaginable at the moment.

Section 2: Personal Care (washing, dressing, etc)

- I can look after myself normally w/out causing extra pain
- I can look after myself normally but it causes extra pain
- It is painful to look after myself and I am slow and careful
- I need some help but can manage most of my personal care
- I need help every day in most aspects of self care
- I do not get dressed, I wash with difficult and stay in bed.

Section 3 : Lifting

- I can lift heavy weights without extra pain
- I can lift heavy weights but it gives extra pain
- Pain prevents me lifting heavy weights off the floor, but i can manage if they are conveniently placed, for example on a table
- Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
- I can only lift very light weights
- I cannot lift or carry anything

Section 4 : Reading

- I can read as much as I want to with no pain in my neck
- I can read as much as I want to with slight pain
- I can read as much as I want with moderate pain
- I can't read as much as I want because of moderate
- I can hardly read at all because of severe pain
- I cannot read at all

Section 5 : Headaches

- I have no headaches at all
- I have slight headaches, which come infrequently
- I have moderate headaches, which come infrequently
- I have moderate headaches, which come frequently
- I have severe headaches, which come frequently
- I have headaches almost all of the time

Section 6: Concentration

- I can concentrate fully when I want to with no difficulty
- I can concentrate fully when I want to with slight difficulty
- I have a fair degree of difficulty in concentrating when I want to
- I have a lot of difficulty in concentrating when I want to
- I have a great deal of difficulty in concentrating when I want to
- I cannot concentrate at all

Section 7 : Work

- I can do as much work as I want to
- I can only do my usual work, but no more
- I can do most of my usual work, but no more
- I cannot do my usual work
- I can hardly do any work at all
- I can't do any work at all

Section 8 : Driving

- I can drive my car without any neck pain
- I can drive my ca as long as I want with slight pain
- I can drive my car as long as I want with moderate pain
- I can't drive my car as long as I want because of moderate pain
- I can hardly drive at all because of severe pain
- I can't drive my car at all

Section 9 : Sleeping

- I have no trouble sleeping
- My sleep is slightly disturbed (< 1 hr sleepless)
- My sleep is mildly disturbed (1-2 hrs sleepless)
- My sleep is moderately disturbed (2-3 hrs sleepless)
- My sleep is greatly disturbed (3-5 hrs sleepless)
- My sleep is completely disturbed (5-7 hrs sleepless)

Section 10 : Recreation

- I am able to engage in all my recreation activities with no neck pain at all
- I am able to engage in all my recreation activities, with some pain in my neck
- I am able to engage in most, but not all of my usual recreation activities because of pain in my neck
- I can hardly do any recreation activities because of pain in my neck
- I can't do any recreation activities at all

SCORING ON REVERSE SIDE

Score _____ / 50

Transform to percentage score x 100

= _____ %

Scoring : For each section the total possible score is 5. If the first statement is marked the section score = 0, if the last statement is marked it = 5. If all ten sections are completed the score is calculated as follows :

Example : 16 (total score) divide by
50 (total possible score) x 100 = 32%

Oswestry Low Back Pain Index

This questionnaire is designed to help us better understand how your back pain affects your ability to manage everyday activities. Please mark ONE LETTER in each section that applies to you. Although you may consider that two statements may apply to you, please mark the one that MOST CLOSELY describes your current condition.

Pain Intensity

- A. Pain comes and goes and is mild.
- B. Pain is mild and does not vary.
- C. Pain comes and goes and is moderate.
- D. Pain is moderate and does not vary much.
- E. Pain comes and goes and is severe.
- F. Pain is severe and does not vary much.

Standing

- A. Can stand for an unlimited amount of time w/o pain
- B. Some pain standing doesn't increase with time.
- C. Cannot stand for more than 1 hour.
- D. Cannot stand for more than 1/2 hour.
- E. Cannot stand for more than 10 minutes.
- F. Cannot stand at all.

Personal Care

- A. Does not change habits to avoid pain.
- B. Does not change habits but have some pain.
- C. Does not change habits but increases the pain.
- D. Changes habits due to pain.
- E. Unable to do personal care without some help.
- F. Unable to wash or dress without help.

Sleeping

- A. No pain in bed.
- B. Gets pain in bed, but sleeps well.
- C. Normal night's sleep reduced by 1/4.
- D. Normal night's sleep reduced by 1/2.
- E. Normal night's sleep reduced by 3/4.
- F. Cannot sleep at all due to pain.

Lifting

- A. Lifts heavy weights with no pain.
- B. Lifts heavy weights with pain.
- C. Cannot lift heavy weights off the floor.
- D. Can lift heavy weights from a table.
- E. Can lift light weights from table.
- F. Can lift only very light weights.

Traveling

- A. Travel without pain.
- B. Travel causes some pain, but not made worse.
- C. Causes extra pain, no change in form.
- D. Causes pain, uses alternative travel.
- E. Pain restricts all form of travel.
- F. Pain restricts except lying down.

Walking

- A. Pain does not prevent walking.
- B. Cannot walk more than 1 mile.
- C. Cannot walk more than 1/2 mile.
- D. Cannot walk more than 1/4 mile.
- E. Can walk only with cane or crutches.
- F. Bedridden and must crawl to toilet.

Social life

- A. Normal and causes no pain.
- B. Normal but causes extra pain.
- C. Limits more energetic interests. (Dancing etc.)
- D. Pain limits me, do not go out as often.
- E. Pain restricts my social life to home.
- F. Pain restricts all social life.

Sitting

- A. Can sit in any chair as long as desired.
- B. Can sit only in favorite chair as long as desired.
- C. Can sit no more than 1 hour.
- D. Can sit no more than 1/2 hour.
- E. Can sit no more than 10 minutes.
- F. Cannot sit at all due to pain.

Changing Degree of Pain

- A. Pain is rapidly improving.
- B. Pain fluctuates but is improving.
- C. Improvement is slow.
- D. Pain level is unchanged.
- E. Pain is gradually worsening.
- A. F. Pain is rapidly worsening.

Patient Name: _____ Date: _____

Signature: _____

Medical Symptoms Questionnaire (MSQ)

Name: _____ Date: _____

Email Address: _____

Rate each of the following symptoms based upon your typical health profile for the **past 30 days**.

- Point Scale
- 0 - Never or almost never have the symptom
 - 1 - Occasionally have it, effect is not severe
 - 2 - Occasionally have it, effect is severe
 - 3 - Frequently have it, effect is not severe
 - 4 - Frequently have it, effect is severe

Head

- _____ Headaches
- _____ Faintness
- _____ Dizziness
- _____ Insomnia

Total _____

Eyes

- _____ Watery or Itchy Eyes
- _____ Swollen, Reddened or Sticky Eyelids
- _____ Bags or Dark Circles Under Eyes
- _____ Blurred or Tunnel Vision
(does not include near or far-sighted)

Total _____

Ears

- _____ Itchy Ears
- _____ Earaches, Ear Infections
- _____ Drainage from Ear
- _____ Ringing in Ears, Hearing Loss

Total _____

Nose

- _____ Stuffy Nose
- _____ Sinus Problems
- _____ Hay Fever
- _____ Sneezing Attacks
- _____ Excessive Mucus Formation

Total _____

**Mouth/
Throat**

- _____ Chronic Coughing
- _____ Gagging, Frequent Need to Clear Throat
- _____ Sore Throat, Hoarseness, Loss of Voice
- _____ Swollen or Discolored Tongue, Gums, or Lips
- _____ Canker Sores

Total _____

Skin

- _____ Acne
- _____ Hives, Rashes, Dry Skin
- _____ Hair Loss
- _____ Flushing, Hot Flashes
- _____ Excessive Sweating

Total _____

Heart

- _____ Irregular or Skipped Heartbeat
- _____ Rapid or Pounding Heartbeat
- _____ Chest Pain

Total _____

The Wellness Score™

Lungs _____ Chest Congestion
 _____ Asthma, Bronchitis
 _____ Shortness of Breath
 _____ Difficulty Breathing
Total _____

Digestion _____ Nausea, Vomiting
 _____ Diarrhea
 _____ Constipation
 _____ Bloating Feeling
 _____ Belching, Passing Gas
 _____ Heartburn
 _____ Intestinal/Stomach Pain
Total _____

**Joints/
Muscles** _____ Pain or Aches in Joints
 _____ Arthritis
 _____ Stiffness or Limitation of Movement
 _____ Pain or Aches in Muscles
 _____ Feeling of Weakness or Tiredness
Total _____

Weight _____ Binge Eating/Drinking
 _____ Craving Certain Foods
 _____ Excessive Weight
 _____ Compulsive Eating
 _____ Water Retention
 _____ Underweight
Total _____

**Energy/
Activity** _____ Fatigue, Sluggishness
 _____ Apathy, Lethargy
 _____ Hyperactivity
 _____ Restlessness
Total _____

Mind _____ Poor Memory
 _____ Confusion, Poor Comprehension
 _____ Poor Concentration
 _____ Poor Physical Condition
 _____ Difficulty in Making Decisions
 _____ Stuttering or Stammering
 _____ Slurred Speech
 _____ Learning Disabilities
Total _____

Emotions _____ Mood Swings
 _____ Anxiety, Fear, Nervousness
 _____ Anger, Irritability, Aggressiveness
 _____ Depression
Total _____

Other _____ Frequent Illness
 _____ Frequent or Urgent Urination
 _____ Genital Itch or Discharge
Total _____

Grand Total _____

Health Satisfaction Score (HSS)

Name: _____ Date: _____

Email Address: _____

Please answer the questions on a scale of 1 to 10, 1 representing that you don't agree with the statement and 10 representing that there is no doubt in your mind or heart that you agree with the statement.

[1 - Absolutely Disagree] [2] [3] [4] [5] [6] [7] [8] [9] [10 - Absolutely Agree]

Section 1 - Physical Health

1. I am a physically fit person and formally exercise on a regular basis.
[1] [2] [3] [4] [5] [6] [7] [8] [9] [10]
2. I have a physically attractive body that I am proud to look at in the mirror.
[1] [2] [3] [4] [5] [6] [7] [8] [9] [10]
3. I have not had many traumas in my life (auto accident, broken bones, bad falls).
[1] [2] [3] [4] [5] [6] [7] [8] [9] [10]
4. I get at least 7 hours of sleep, 7 days at week
[1] [2] [3] [4] [5] [6] [7] [8] [9] [10]
5. I have gotten regular Chiropractic care within the past 5 years.
[1] [2] [3] [4] [5] [6] [7] [8] [9] [10]

Section 1 total _____

Section 2 - Emotional/Mental Health

6. I am a calm, peaceful person. I can shut my mind off and focus my mind at will.
[1] [2] [3] [4] [5] [6] [7] [8] [9] [10]
7. I practice some form of mental relaxation (meditation, yoga, breathing exercises, prayer, etc.) on a regular basis.
[1] [2] [3] [4] [5] [6] [7] [8] [9] [10]
8. Most of the time, I am truly happy and feel a sense of purpose in my life.
[1] [2] [3] [4] [5] [6] [7] [8] [9] [10]
9. I have healthy relationships and a rich social network of friends and activities.
[1] [2] [3] [4] [5] [6] [7] [8] [9] [10]
10. I am organized, have time for myself, and can prioritize the important tasks in my life.
[1] [2] [3] [4] [5] [6] [7] [8] [9] [10]

Section 2 total _____

Section 3 - Chemical/Nutritional Health

11. I eat 4-6 small meals daily and properly combine my protein, carbs. and fats.
[1] [2] [3] [4] [5] [6] [7] [8] [9] [10]
12. I supplement everyday with good supplements such as a vitamin/mineral complex, antioxidants, and good fatty acids (fish oil, flax seeds).
[1] [2] [3] [4] [5] [6] [7] [8] [9] [10]
13. I do not take medications for chronic medical problems such as digestive disorders; cardiovascular problems; headaches; chronic pain; blood sugar problems; chronic fatigue; immune problems or chronic infections; or any other chronic conditions.
[1] [2] [3] [4] [5] [6] [7] [8] [9] [10]
14. I do not smoke cigarettes.
[1] [2] [3] [4] [5] [6] [7] [8] [9] [10]
15. I drink water as my primary beverage and consume at least 30 ounces per day.
[1] [2] [3] [4] [5] [6] [7] [8] [9] [10]

Section 3 total _____

Grand total of all three sections: _____