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 ☐ No ☐ Medication Yes ☐ No ☐ If yes: _____

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

InnerSun
FAMILY CHIROPRACTIC, LLC

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.

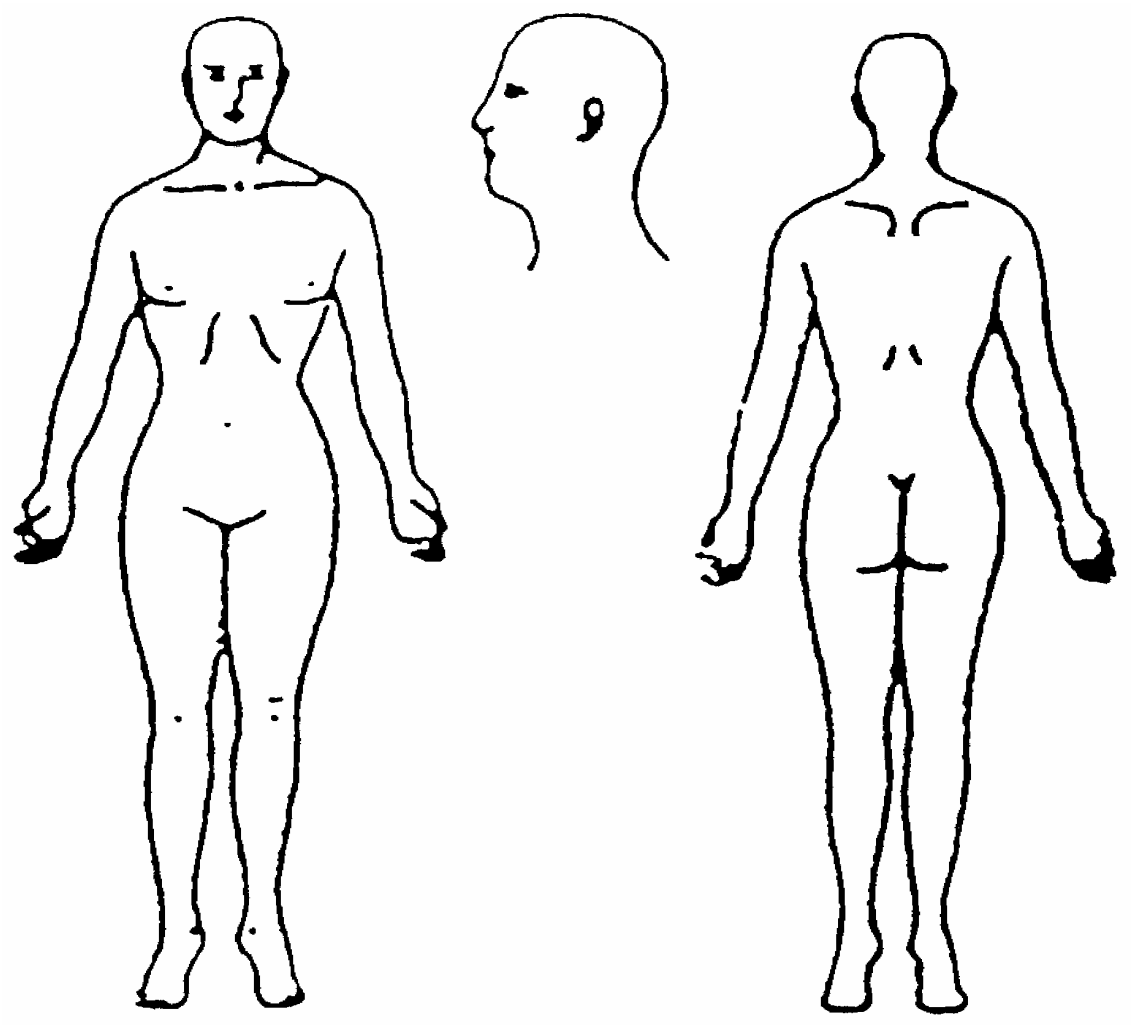
Patient or Guardian Signature: _____ Date: _____/_____/_____

SYMPTOM DIAGRAM

Name _____ Number _____ Date _____

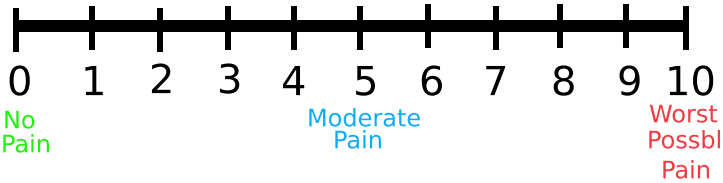
Please be sure to fill this form out extremely accurately. Mark the area(s) on your body where you feel the described sensation(s). Use the appropriate symbol(s). Mark areas of radiating pain, and include all affected areas. You may draw on the face as well.

Aches ΛΛΛΛ 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_____

Neck Disability Index **Name:** **Date:**

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 was with difficulty 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 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 pain
- ❑ 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 car 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 of 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

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.

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.

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.

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.

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.

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.

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.

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.

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.

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 _____

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

Total _____

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

Total _____

Joints/	_____	Pain or Aches in Joints
Muscles	_____	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/	_____	Fatigue, Sluggishness
Activity	_____	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: _____