CONNECTED LIFE CHIROPRACTIC

Phone: 405-920-6440
Fax:405-920-6446

Thank you for taking time to fill out the following forms. Our mission is to serve each individual by providing quality care that allows you to express the best part of who you were created to be by encouraging unity of spirit, mind, soul, and body. Our focus will be to help bring your system into a state of balance/ease, to assist you as you become more aware, stronger, and empowered in your health, & to create supports for you to better adapt to stress and activities of daily living.

Step one in our time together is learning more about you – the whole person. We understand that health expression is multi-faceted (physical, chemical, emotional/mental). Reviewing each aspect and the stressors in each category help us paint the whole picture and decide where to go from here.

We are honored to have you here. Our team will take amazing care of you & your family!

PREGNANCY INTAKE - BASIC DEMOGRAPHICS

Legal Name: _____ Today's Date: _____

Nickname/Preferred Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Gender: ☐ Male ☐ Female

Phone: (h) _____ (c) _____ (w) _____

Email: _____

Preferred Method of Contact: ☐ Call – *Home, Cell, or Work* ☐ Text ☐ Email

For Minors, Legal Guardian Name(s): _____

Who can we thank for referring you? _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Home: _____ Mobile: _____

Primary Care Physician: _____

Office Number: _____

WHAT BRINGS YOU HERE?

People seek Chiropractic care for a variety of reasons depending on personal needs, expectations, perceptions, and past experiences. We want to do our best to understand so that our team can meet your specific needs. Please check those that apply to you:

RELIEF CARE

☐ Pain reduction ☐ Symptom relief
☐ Crisis Management ☐ Stress reduction

CORRECTIVE CARE

☐ Improved function ☐ Increased strength
☐ Improved movement ☐ Improved performance

HOLISTIC CARE

☐ Improved quality of life ☐ Prevention
☐ Improved immune system function
☐ Optimum nervous system function
☐ Full body integration ☐ Longevity

OTHER

_____
_____
_____

Patient/Guardian Signature: _____ Date: _____

Office Rep. Initial: _____

www.liveconnectedchiro.com
info@liveconnectedchiro.com

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PREGNANCY QUESTIONNAIRE

Name: _____ Date: _____

PREVIOUS BIRTH EXPERIENCE

Is this your first pregnancy? ☐ Yes ☐ No

No

If not, please tell us about your previous pregnancy and/or birth experience(s). *(Duration, interventions, etc.)*

_____

_____

CONCEPTION & EARLY PREGNANCY

Expected due date?_____

Did you have any difficulty conceiving?? ☐ Yes ☐ No No

If yes, please explain: _____

_____

Have you ever used hormonal contraceptives? ☐ Yes ☐ No

If so, which ones and for how long?_____

What was your pre-pregnancy weight?_____Current weight?_____

Have you experienced morning sickness? ☐ Yes ☐ No

If so, please explain:_____

CURRENT HEALTH CONDITIONS

What type of exercise(s) are you currently performing?_____

Your current diet or dietary restrictions?_____

Are you taking any medications or supplements during this pregnancy ☐ Yes ☐ No

If yes, please explain:_____

Any slips, falls, or physical traumas during this pregnancy? ☐ Yes ☐ No

If yes, please explain:_____

Any emotional stressors during this pregnancy? ☐ Yes ☐ No

If yes, please explain:_____

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PREGNANCY QUESTIONNAIRE

Name: _____ Date: _____

YOUR BIRTH PLAN

Your top three goals for this pregnancy:

1._____

2._____

3._____

Do you currently have a birth plan? ☐ Yes ☐ No

If yes, please explain:_____

_____

Are you taking any pre-natal or birthing classes? ☐ Yes ☐ No

If yes, please explain:_____

_____

Who is your OBGYN/Midwife?_____

Will they be present at the delivery? ☐ Yes ☐ No

Who is your birth provider?_____

Do you intend on having a doula or birth coach present? ☐ Yes ☐ No

If yes, please explain:_____

_____

Do you wish to have a natural vaginal labor and delivery? ☐ Yes ☐ No

If not, what concerns do you have?_____

Do you intend on breastfeeding? ☐ Yes ☐ No

What do you intend to do for vaccines?_____

Any other information about your pregnancy or birth plan that I should know about?

_____

Patient/Guardian Signature: _____ Date: _____

Office Rep. Initial: _____