Mother Goose Chiropractic
3358 Woods Edge Circle #103
Bonita Springs, FL 34134

New Patient Information

Full Name: _____ Date: _____

Names you go by (Nicknames): _____ Email: _____

Address: _____ City: _____ State: ____ Zip: _____

Date of Birth: _____ Primary Phone #: _____ Best time to call: _____

Employer: _____ Work Phone #: _____ Occupation: _____

Address: _____ City: _____ State: ____ Zip: _____

Number of Children: _____ Ages of Children: _____ Referred by: _____

Marital Status: S M D W SEP Name of Spouse/Partner: _____

Name and number of person to contact if we cannot reach you: _____

Do you live here full time or seasonal? _____

Any impending vacation or travel plans? Yes No

The practice of chiropractic is based upon the location and adjustment of vertebral subluxations. These spinal subluxations are caused by any stress to which your body cannot adapt. These stresses may be **physical**, **chemical** or **emotional** in nature.

Health Information

What brings you to out office today? _____

When did this condition begin? _____

Is this condition getting worse? Yes No How do you rate the pain from 1 (least) to 10 (severe)? _____

Type of pain (circle): Achy Tight Tense Sharp Stiff Stabbing Throbbing Burning Tingling Numb Dull

Nature of the pain (circle): Constant Frequent Intermittent Episodic

What makes the pain better? _____

What makes the pain worse? _____

Does your pain interfere with (circle): Work Sleep Recreation Activities of Daily Living Everyday Life

Have you seen anyone for this condition? _____

Is this condition job or auto accident related? _____

List any other complaints/pains? _____

Supplements you're currently taking. _____

Medications currently taking and what for? _____

How do you rate your physical health? Excellent Good Fair Poor

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Do you exercise regularly? _____

Do you have any chronic illnesses? _____

List any surgeries you have had: _____

List any accidents/injuries/broken bones: _____

Do you have any congenital disorders? _____

Did you have any childhood illnesses or injuries? _____

Lifestyle and Habits – Please list amounts of each:

Coffee/Caffeine: _____ Alcohol: _____ Non-Caffeinated fluids/Water: _____

Tobacco: _____ Exercise: _____ Sleep: _____

Have you ever received Chiropractic care? Y N If yes, your Doctor and where? _____

Approximately how long were you under care? _____ Date of last visit? _____

Why did you stop? _____

Pregnancy History

Were there any difficulties or irregularities of your menses prior? _____

Were there any difficulties getting pregnant? _____

Due date/week _____ I am in my: _____ week of pregnancy.

Pre-pregnancy weight: _____ Current weight: _____ Height _____

Childbirth caregiver(s): OB/GYN _____ Doula _____ Midwife _____

Last visit to caregiver _____ Care giver name and phone # _____

I plan of giving birth at: Hospital _____ Home _____ Birth Center _____

Name of Hospital or Birth Center: _____

Any ultrasounds performed? If yes, how many? _____

Any traumas during this pregnancy? If yes, please explain: _____

_____

Any hospitalizations during this pregnancy? If yes, please explain: _____

_____

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Any medications during this pregnancy, including over the counter medication? If yes, please explain: _____

_____

Any fertility treatments? If yes, please explain: _____

_____

Any other information about your pregnancy we should know: _____

_____

After 32 Weeks

Position of baby: Head down _____ Posterior _____ Breech of malposition _____

Confirmed by: _____ Location: _____

Palpation by: _____ Date: _____

Ultrasound by: _____ Date: _____

How long do you believe baby has been in this position? _____

Previous Pregnancies/Births

Did you have chiropractic care during any previous pregnancies? Please circle one: Yes or No

# of previous pregnancies: _____ # of previous births: _____

Please explain any discrepancy: _____

Name and ages of children: _____

Your previous births were at: Hospitals_____ Home_____ Birth Center_____

Medications used in prior births: None _____ Pitocin _____ Epidural

_____

Interventions used in prior births: Breaking of water _____ Vacuum _____ Forceps _____ Episiotomy _____

How long was your previous labor? Total _____ Time before you pushed _____

Time you spent pushing: _____

Additional Information

_____

_____

_____

_____ _____

Patient Signature Doctor Signature

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Health History

General
__ Chills
__ Depression
__ Dizziness
__ Fainting
__ Fever
__ Forgetfulness
__ Headache
__ Loss of sleep
__ Nervousness
__ Sweats

Eyes
__ Crossed eyes
__ Double Vision
__ Vision flashes
__ Vision halos
__ Vision blurred

Ears/Nose/Throat
__ Ear ache
__ Ear discharge
__ Ringing in ears
__ Loss of hearing
__ Hay fever
__ Sinus problem
__ Nose bleeds
__ Bleeding gums
__ Hoarseness
__ Difficulty swallowing
__ Persistent cough

Respiratory
__ Shortness of breath
__ Cough
__ Distress
__ Sputum

Genito-Urinary
__ Blood in urine
__ Frequent urination
__ Lack of bladder control
__ Painful urination
__ Venereal disease

Endocrine
__ Weight gain
__ Weight loss
__ Hoarseness
__ Heat Intolerance
__ Cold Intolerance
__ Breast Changes
__ Hair Changes
__ Extreme Thirst

Gastrointestinal
__ Appetite loss
__ Bloating
__ Bowel changes
__ Constipation
__ Diarrhea
__ Excessive hunger
__ Excessive thirst
__ Gas
__ Hemorrhoids
__ Indigestion
__ Nausea
__ Rectal Bleeding
__ Stomach pain
__ Vomiting - no blood
__ Vomiting - blood

Cardiovascular
__ Chest pain
__ High blood pressure
__ Low blood pressure
__ Irregular heart beat
__ Poor circulation
__ Rapid heart beat
__ Swelling of ankles
__ Varicose veins

Women only
__ Abnormal pap smear
__ Bleeding between periods
__ Breast lumps
__ Extreme menstrual pain
__ Hot flashes
__ Nipple discharge
__ Painful intercourse
__ Vaginal discharge
__ Other:

Date of last menstrual period:
_____

Date of last pap smear:
_____

Have you had a mammogram?
_____

Are you pregnant?
_____

Number of children?
_____

Men only
__ Erectile dysfunction
__ Lump in testicles
__ Penis discharge
__ Sore on penis
__ Other :

Integumentary
__ Bruise easily
__ Hives
__ Change in moles
__ Sores that do not heal
__ Itching
__ Unusual swelling
__ Sores/Ulcers
__ Rash
__ Scars

Neurological
__ Seizures
__ Vertigo
__ Dizziness
__ Hand Tremors
__ Loss of sensation
__ Loss of facial expression
__ Weak grip
__ Paralysis
__ Difficulty of speech
__ Tingling
__ Loss of memory
__ Numbness
__ Un-Coordination

Muscle/Joint/Bone
__ Back pain
__ Neck pain
__ Arm pain
__ Leg pain
__ Hip pain
__ Foot pain
__ Shoulder pain
__ Hand pain

Psychiatric
__ Hyperventilation
__ Insecurity
__ Depression
__ Trouble sleeping
__ Irritable
__ Anxiousness
__ Undecidedness
__ Timid
__ Hallucinations
__ Loss of memory
__ Alcoholism
__ Drug addiction
__ Extreme worry
__ Sexual problems
__ Suicidal thoughts
__ Other:

Conditions
__ AIDS
__ Alcoholism
__ Anemia
__ Anorexia
__ Appendicitis
__ Asthma
__ Bleeding Disorders
__ Breast Lumps
__ Bronchitis
__ Breath Shortness
__ Bulimia
__ Cancer
__ Cataracts
__ Chemical dependency
__ Chicken pox
__ Diabetes
__ Emphysema
__ Epilepsy
__ Glaucoma
__ Goiter
__ Gonorrhea
__ Gout
__ Heart disease
__ Hepatitis
__ Hernia
__ Herpes
__ High cholesterol
__ HIV positive
__ Kidney disease
__ Liver disease
__ Measles
__ Migraine headaches
__ Mononucleosis
__ Multiple Sclerosis
__ Mumps
__ Pneumonia
__ Polio
__ Prostate problem
__ Rheumatic fever
__ Scarlet fever
__ Stroke
__ Suicide attempt
__ Thyroid problems
__ Ulcers
__ Other:

Medications:

Allergies: