Name (Last, first, m.):		Age:	Date of Birth_____/_____/_____
Address:			City, State, Zip
Cell Phone:	Home Phone:		Work Phone:
Email address:	Occupation:		Employer:
Sex: ☐ M ☐ F	Marital Status: ☐ M ☐ S ☐ D ☐ W		Children and ages:
Closest Relation:			Phone:
Who may we thank for your referral to this office?			

Your Health Profile

Please briefly describe the chief area of complaint, including the effect it has on you life.

My main complaint:_____
If you are experiencing pain is it: ☐Sharp ☐ Dull ☐ Comes and goes ☐Constant ☐Burning ☐Other
Since the problem began is it:☐About the same ☐Getting worse ☐ Getting better ☐ Comes and goes
What makes it worse?_____
What makes it better?_____
It interferes with: ☐Work ☐ Sleep ☐ Walking ☐ Sitting ☐ Standing ☐ Stairs ☐ Lifting ☐ Home life
I believe that the cause of my problem is:_____
I first noticed my problem:_____
Other doctors seen for this problem and what they did: ☐ Chiropractor_____
☐ Medical Doctor _____
☐ Other_____
Past Chiropractic care: When?_____ Who was your chiropractor?_____
Vitamins you take regularly and amounts:_____
_____

Your stress history

Please indicate whether you have <u>ever</u> experienced stress in the following areas. Your answers will enable us to determine which experiences have contributed to your present health concerns.

Your Birth, Infancy and Childhood Years

☐ Difficult or Prolonged Labor	☐ Fall/Jump from height < 3 feet; age_____
☐ Breech position and/ or C-section	☐ Fall/Jump from height> 3 feet; age_____
☐ Drugs during labor	☐ Car accidents; age_____
☐ Forceps/ Vacuum extraction	☐ Beating, Child abuse
☐ Ear Infections	☐ Youth sports, which; age_____
☐ Repeated antibiotic use; age_____	☐ Head Trauma
☐ Childhood illnesses:	☐ Broken bones
☐ Prescription Medications	☐ Other Traumas
☐ Inhaler use	☐ Regular chiropractic health care throughout childhood

Adult (18 to present)

☐ Smoking	☐ Contact/ Extreme Sports
☐ Coffee Drinker	☐ Alcohol/ Drug Abuse
☐ Car Accidents; when	☐ Fall/ Jump from a height
First day of your last menstrual period_____/_____/_____	Could you possibly be pregnant? ☐ Yes, ☐ No
Your Height: _____	Your Weight: _____

Your Health History

Please check off all symptoms or conditions that you have experienced. Circle those symptoms that you currently are experiencing.

☐ Allergies, Asthma	☐ Digestive Problems	☐ Neck Pain/ Stiffness
☐ Anxiety	☐ Dizziness, Vertigo	☐ Numbness in hands and/or feet
☐ Arthritis	☐ Frequent Colds	☐ Osteoporosis
☐ Asthma/ Bronchitis	☐ Headaches, Migraines	☐ Shoulder pain
☐ Arm pain	☐ Heart Conditions	☐ Sinus Problems
☐ Back Pain	☐ Hip pain	☐ Sleep Problems/ Insomnia
☐ Cancer, Type_____	☐ Immune System Disorders	☐ Stroke or TIAs
☐ Circulatory Problems	☐ Infertility	☐ Tingling (Pins and needles) in arms and/or legs
☐ Depression	☐ Kidney Disease	☐ TMJ (Jaw) Problems
☐ Diabetes	☐ Severe Menstrual Symptoms, Cramps	☐ Urinary Problems
☐ Diarrhea, Constipation	☐ Leg pain	☐ Yeast Infections
☐ _____	☐ _____	☐ _____

Are there any other health concerns that we should be aware of? ☐ No ☐ Yes_____

_____

Are you pregnant or breastfeeding? ☐ Yes, ☐ No
Do you have problems sleeping? ☐ Yes, ☐ No; Why?_____
What position do you sleep in? ☐ Side, ☐ Back, ☐ Stomach
Do you exercise regularly? ☐ Yes, ☐ No; If yes, what exercise do you enjoy?_____

List previous surgeries and dates

Medications (prescription and over the counter): ☐ Pain Meds ☐ Anti-inflammatories ☐ Birth control ☐ Heart Meds ☐ Cholesterol Meds

☐ Antidepressants ☐ Other_____ Prescribed by_____

Chiropractic Defined

Chiropractic is a health care discipline which emphasizes the inherent recuperative power of the body to heal it-self without the use of drugs or surgery.

The practice of chiropractic focuses on the relationship between structure (primarily the spine) and function (as coordinated by the nervous system) and how that relationship affects the preservation and restoration of health. In addition, Doctors of Chiropractic recognize the value and responsibility of working in cooperation with other health care practitioners when in the best interest of the patient.

I understand that the chiropractors in this office provide chiropractic adjustments to treat musculoskeletal complaints. I understand that all charges are due and payable at the time of service until I have provided insurance information that will cover all charges.

_____ _____/_____/_____
Signature Date

I hereby give permission for Dr. Lundquist and Dr. Patterson to care for my minor child as they deem necessary.

_____ _____/_____/_____
Signature Date

PRENATAL CHIROPRACTIC INTAKE FORM

This form is in addition to our regular patient history form in order for us to have the necessary information to care for you during your pregnancy.

CURRENT PREGNANCY

Patient name_____ Date ____/____/20____

Due Date/Week_____, I am in my _____week of pregnancy.
Prepregnancy weight _____, Current weight _____ Height_____
Childbirth preparation: ☐ Bradley, ☐ LaMaze, ☐ Other_____
Childbirth caregiver(s): ☐ Doula, ☐ Midwife, ☐ OB/GYN, _____
Last visit to Caregiver: ___/___/___; Caregivers name and phone #_____
_____
I plan on giving birth at : ☐ Birth Center, ☐ Home, ☐ Hospital; Name and address of birth center or hospital _____
What position do you sleep in? _____
Any traumas during this pregnancy? If yes, Please describe_____
_____
Any hospitalizations during this pregnancy? If yes, Please describe_____
_____
Any medication during pregnancy, including over the counter medication? Please describe_____
_____
Any fertility treatment? Please describe_____
Prior gynecological treatments (LEEP, Cervical Cryotherapy, etc)?_____
_____
Any other information you would like us to know about you and your pregnancy?_____
_____
_____

PREVIOUS PREGNANCIES/BIRTHS

of previous pregnancies____, # of previous births ____; explain any difference in numbers_____
Names and ages of children_____
Your previous births were at : ☐ Birth Center, ☐ Home, ☐ Hospital
Medications used in prior births: ☐ None, ☐ Ptocin, ☐ Epidural,
Interventions used in prior births: ☐ IV, ☐ External monitor, ☐ Internal monitor, ☐ Breaking of waters, ☐ Vacuum, ☐ Forceps, ☐ Episiotomy
How long was your previous labor: Total:_____, Time before you pushed _____,
Time you spent pushing:_____
Childbirth preparation: ☐ Bradley, ☐ LaMaze, ☐ Hypnobabies, ☐ Other_____

Did you have Chiropractic care during your previous pregnancy? ☐ Yes, ☐ No

After the 32nd week of Pregnancy

Position of Baby: ☐ Head down, ☐ Posterior, ☐ Breech or malpositioned
Confirmed by: ☐ Palpation by _____ on ___/___/____
☐ Ultrasound by _____ on ___/___/____

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

The Webster Technique Defined

International Chiropractic Pediatric Association definition of Webster Technique:

The Webster technique is a specific chiropractic analysis and adjustment that reduces interference to the nervous system, balances out pelvic muscles and ligaments which in turn removes torsion to the uterus, reducing the potential for intrauterine constraint and allows the baby to get into the best possible position for birth.

Statement to pregnant patients of Anne Lundquist , DC

I understand that Anne Lundquist, DC provides chiropractic adjustments to treat musculoskeletal complaints in patients, including pregnant women..

____/_____/_____
Date

_____ _____
Print name Sign name