FINGER LAKES FAMILY CHIROPRACTIC & WELLNESS, P.C.
THE OFFICE OF DRS. MIKE AND MEREDITH VOROZILCHAK

Pregnancy Intake Form

Name:_____ Date:_____

Street Address:_____City / State / Zip:_____

E-Mail:_____ Date of Birth:_____ Age:_____

Home Phone:(___)_____Cell Phone:(___)_____Work Phone:(___)_____

Marital Status: S M D W Name of Spouse / Significant Other:_____

Names / Ages of Children (if still part of your household):_____

Occupation:_____Employer:_____

Emergency Contact:_____ How they could be reached:_____

How did you hear about us? Whom may we thank for recommending you to our office?_____

Tell Us About Your Pregnancy and Goals For Care:

What results are hoping to experience by working with our office?_____

_____

Have you ever been under chiropractic care in the past? Yes/No, With whom and when?_____

What is your estimated due date?_____ Gender(s) if known:_____

Where do you plan on giving birth?_____ Do you have a written birth plan? Yes/No

Please list the providers you are working with during your pregnancy and your labor / delivery (OB/GYN, midwives, doulas, other):_____

Which of the following did you experience with previous pregnancies (circle all that apply):

Vaginal Delivery / Caesarean Delivery / VBAC / Induction / Epidural / Homebirth / Pre-eclampsia / Bedrest / Forceps / Pre-term Delivery / Vacuum Extraction / Episiotomy / Tearing / Back Pain / Pelvic Pain / Sciatic Pain / Headaches / Numbness in Hands or Feet / Complications / Other:_____

_____

Which of the following are you anticipating for your upcoming birth (circle all that apply):

Vaginal Delivery / Caesarean Delivery / VBAC / Induction / Epidural / Water Birth / Other:_____

How would you describe your pregnancy to date? Have there been any complications / concerns or are things progressing as you would hope / expect?_____

_____

Please list any diagnosed health conditions:_____

What medications are you currently taking or have you taken during pregnancy?_____

_____

What supplements are you taking?_____

How many ultrasounds have you had?_____ How many do you plan on having?_____

Do you or anyone in your household smoke? YES / NO

Have you had or do you intend to have any vaccinations during pregnancy, including the flu shot? Yes/No

Please list any additional information you'd like us to be aware of:_____

"I agree that the information submitted on this form is true and accurate to the best of my knowledge."

Signature:_____ Date:_____

Congrats on your pregnancy and thank you for choosing our office! We look forward to serving you!

Office use only:

Notes:_____

_____ Listings:_____

Posture: RHF / LHF / RHT / LHT / AHT / RTT / LTT Dec ROM: RHR / LHR / RHF / LHF / CF / CE / RTR / LTR / RTF / LTF

Supine LLI: Left / Right Prone LLI: Left / Right Recc:_____