HOLISTIC INSTITUTE OF
Health & Fertility

SOUTH 143, 14919 Deer Ridge Dr. SE, Calgary T2J 7C4
Tel: 403.455.8029 **Email:** south@holisticinstitute.ca

NORTH 150, 4411 16th ave NW Calgary, AB T3B 0M3
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HIHF CHIROPRACTIC PRENATAL INTAKE FORM

Patient Information

Date: _____

Preferred Name: _____ Last Name: _____
Date of Birth (M/D/Y): _____ Age: ____ Gender Pronoun:

Address: _____

City: _____ Province:_____ Postal Code: _____

Contact Information

Home: _____
Business: _____
Cell**:**_____
Email Address: _____

Referral Information

Personal referral: _____
Doctor/physiotherapist/acupuncturist/massage therapist/yogi/midwife/doula referral:
_____

Health Care Providers

Family Doctor: _____ Massage Therapist: _____
Acupuncturist/Naturopath: _____ OB/GYN: _____
Other Care Providers: _____

Insurance

Do you have Extended Health Coverage? Y/N
Insurance Company: _____

Motor Vehicle Accident / Work related (if applicable)

Is this condition related to: Work? □ Yes □ No Has your employer been notified? □ Yes □ No
Motor vehicle accident? □ Yes □ No Date of injury: _____
Have you seen another practitioner in regards to this accident? Y/N
Practitioner Name: _____

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Prenatal Questionnaire

Pregnancy profile – please check/circle/fill in the following information to give us a detailed picture of your pregnancy.

I am in my first in my 1st/2nd/3rd trimester

I am _____ wks My Due Date is _____

I am planning to have my birth at _____

This is my (1st/2nd/3rd /4th …?) _____ pregnancy

I am under the care of the following health care providers (OBGYN/Midwife/Doula)
_____Have there been any issues/concerns with any of your check-ups so far? If so please explain
_____

I am currently experiencing the following: (please circle applicable items)

Nausea / vomiting / dizziness
Fatigue
Stress / worry / fear
Sleep disturbance
Swelling
Cramping
Spotting
Gestational Diabetes
High/ Low Blood Pressure
Shortness of breath
Difficulty walking/sitting/standing
Pain

Under the ribs;
In my low back/pelvis/pubic bone
On the sides of my hips
In my arms / legs
In my neck
Across my shoulders/between my shoulder blades
Tension/pulling under my belly
Other (please explain)
_____
_____

The position of my baby is: Head down / Transverse / Breech / Unknown

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Prenatal Questionnaire

Describe your previous birth experience

Vaginal delivery / C-section / vacuum / forceps _____

Episiotomy _____

_____

Induction _____

Epidural _____

Labour time _____

Baby weight _____ length _____

Breastfeed _____ for how long? _____

Have you been diagnosed with any health conditions as a child or through your adult life? Please list

_____Please describe any over the counter or prescription medications you are currently taking

_____Please list all supplements/vitamins that you are currently taking

_____Do you have any specific concerns you'd like us to address?

_____Can we provide you with more information about Prenatal-

Acupuncture / Massage / Chiropractic / Nutrition / Yoga / Counseling / Doula support/ post-partum support / lactation consulting / Prenatal classes /

Other resources

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Current Health Condition

*Reason for this appointment/major complaint:_____

_____

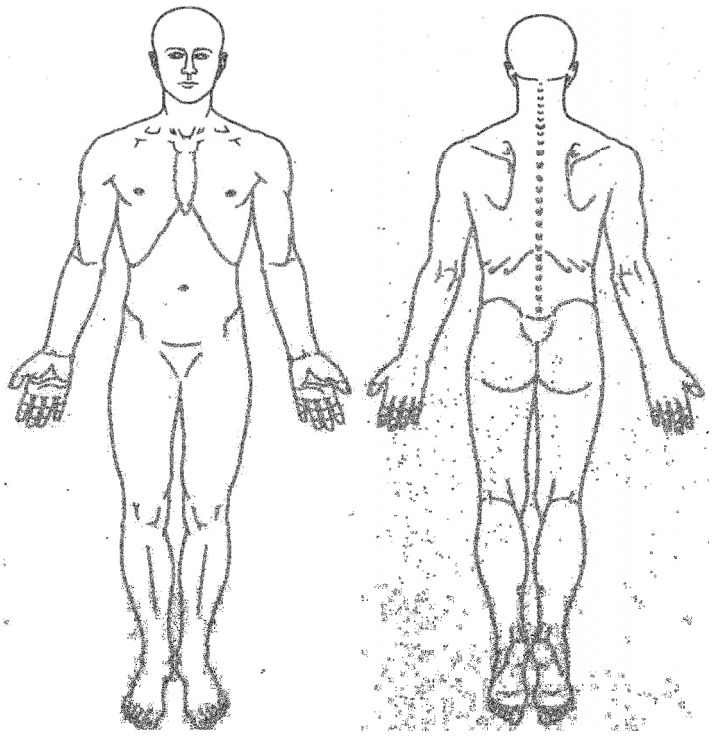
*How did this compliant occur:

_____

*When did your condition begin: _____days /weeks /months/years
*Have you had this condition before: Y/N
*Is your condition getting: Better/ Worse/ No change
*Symptoms came on: Suddenly/ Come & Go
*Indicate the **severity** of the **pain** by circling one of the following numbers:
(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Extreme Pain)

*Please use the symbols below to mark on the pictures where you are experiencing your current pain.

Numbness	= = =
Dull Ache	OOO
Burning	XXX
Sharp/Stabbing	/ / /
Pins, Needles	+ + +
Other _____	^ ^ ^



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*Describe the character of your pain: (dull & achy, sharp/stabbing, shooting, throbbing)

_____

*What activities make this condition better? (ice, heat, stretching, resting):

_____

*What activities make this condition worse? (activity, certain movements, prolonged standing/sitting):

_____

*Have you experienced radiating pain/ numbness/ tingling/ weakness since your condition began. If so please specify where:_____

*Symptoms are BETTER in: AM / midday / PM/ Do not change with time of day
*Symptoms are WORSE in: AM / midday / PM / Do not change with time of day
*Can you perform your daily activities: Y/N/some
*Can you perform your daily work activities: Y/N/some
*Have you seen other Doctors/Health Care Providers for this condition?:

_____

*Please list ALL medications/supplements you are taking (prescriptions, vitamins, herbal supports, BCP, aspirin etc):_____
(for what conditions):_____

*Have you had previous Chiropractic Care: Y/ N Doctor: _____Date:_____

Habits:

Caffeine: cups/days: _____ Smoking: packs/day: _____ Alcohol: drinks/wk: _____

Sleep: hours/night: _____ Exercise: none/moderate/daily What kind: _____

Stress level: none /mild /moderate /high

Past Health History:

Have you ever been diagnosed with any of the following:

*High blood pressure: Y/N *Hardening of arteries (arteriosclerosis): Y/N *Diabetes: Y/N
*Heart/blood disease: Y/N *Stroke: Y/N *Arthritis: Y/N
*Fibromyalgia: Y/N *Cancer: Y/N _____ *Other conditions:_____

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Family History:

Is there a **history in your family** of cancer, diabetes, heart attack, high blood pressure, stroke, arthritis or neck/back pain?
Father_____Mother_____Siblings_____Grandparents:_____

SYSTEMS REVIEW: Please **CHECK** any of the following conditions you are experiencing **currently** and **UNDERLINE** those you have experienced in the **past**:

GENERAL SYMPTOMS
- ☐Fever
- ☐Sweats
- ☐Fainting
- ☐Sleep disturbance
- ☐Fatigue
- ☐Nervousness
- ☐Weight loss
- ☐Weight gain

NEUROLOGICAL
- ☐Visual disturbance
- ☐Dizziness
- ☐Fainting
- ☐Convulsions
- ☐Headache
- ☐Numbness
- ☐Neuralgia (nerve pain)
- ☐Poor coordination
- ☐Weakness

MUSCLE & JOINT
- ☐Neck pain
- ☐Low back pain
- ☐Arm pain
- ☐Shoulder pain
- ☐Leg pain
- ☐Knee pain
- ☐Foot pain
- ☐Pain/numbness in arms/legs
- ☐Pain between shoulders
- ☐swollen joints
- ☐Spinal curvature
- ☐Arthritis
- ☐Fractures

RESPIRATORY
- ☐Chronic cough
- ☐Spitting up phlegm
- ☐Spitting up blood
- ☐Chest pain
- ☐Wheezing
- ☐Difficulty breathing
- ☐Asthma

CARDIOVASCULAR
- ☐Rapid beating heart
- ☐Slow beating heart
- ☐High blood pressure
- ☐Low blood pressure
- ☐Pain over heart
- ☐Hardening of arteries
- ☐Swollen ankles
- ☐Poor circulation
- ☐Palpitations
- ☐Cold hand or feet
- ☐Varicose veins

EARS/EYES/NOSE/THROAT
- ☐Eye pain
- ☐Double vision
- ☐Ringing in ears
- ☐Deafness
- ☐Nosebleeds
- ☐Trouble swallowing
- ☐Hoarseness
- ☐Sinus infection
- ☐Nasal drainage
- ☐Enlarged glands

GENITOURINARY
- ☐Frequent urination
- ☐Painful urination
- ☐Blood in urine
- ☐Pus in urine
- ☐Kidney infection
- ☐Prostate trouble
- ☐Uncontrollable urine flow

GASTROINTESTINAL
- ☐Poor appetite
- ☐Difficult digestion
- ☐Heartburn
- ☐Ulcers
- ☐Nausea
- ☐Vomiting
- ☐Constipation
- ☐Diarrhea
- ☐Blood in stool
- ☐Gallbladder/jaundice
- ☐Colitis/Chrohns

FOR WOMEN ONLY
- ☐Painful menstruation
- ☐Hot flashes
- ☐Irregular cycle
- ☐Cramps or back pain
- ☐Vaginal discharge
- ☐Nipple discharge
- ☐Lumps in breast
- ☐Menopausal symptoms
- ☐Birth control pills
- ☐Miscarriages
- ☐Complications with pregnancy

List any **Surgeries**:_____
List any **Hospitalizations**:_____
List any **Accidents/Falls**:_____

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HIHF CLINIC CANCELLATION POLICY

We understand at the Holistic Institute of Health and Fertility (HIHF) that unplanned events can come up and you may need to cancel an appointment. If that happens, we respectfully ask for scheduled appointments to be cancelled at least 24 hours in advance.

We want to be available for your needs and the needs of all our clients. When a client does not show up for a scheduled appointment, another client loses an opportunity to be seen. In the event of a missed appointment or an appointment cancelled within less than 24 hours notice, you will be charged the **FULL FEE.**

MasterCard, Visa and American Express are accepted at the clinic. Your credit card number will be kept on file to book/hold your appointment. Your credit card will only be charged should an appointment be missed without notifying the HIHF clinic.

Please indicate your acceptance of this policy by signing below. You are a valued patient, thank you for your understanding and cooperation.

Signature: _____ Printed Name: _____

Date: _____

Signature of Parent or Guardian if the Patient is under 18 years of age: _____

HIHF CLINIC WAIVER

I understand that I should be evaluated by a physician for the condition I am requesting consultation. The diagnosis and treatment plan I will be given by the Holistic Institute of Health and Fertility (HIHF) is based on traditional Chinese medicine, and/or therapeutic massage, and/or yoga principles only and does not constitute a Western Medical diagnosis. I understand that I am not to rely on these therapeutic diagnosis and treatments as my sole remedy for the treatment I am seeking. I understand there may be some minor risks associated with these therapies including but not limited to slight bleeding, bruising, and mild dizziness. I understand clinic staff may review my records but all information will be kept confidential and will not be released without my written consent. If no substantial improvement is made in the condition for which I am seeking consultation, I am to seek advice from a Western Medical doctor. Further, if I am concurrently undergoing Western Medical treatments, it is my responsibility to advise my physician of any of these therapies and/or herbal supplements I am concurrently taking. I assume all risks and responsibilities for myself and release HIHF clinic and its agents from any injury or liability that may occur during a treatment session.

Please sign and date below to indicate that you have read and understood this form.

Signature: _____ Printed Name: _____

Date: _____

Signature of Parent or Guardian if the Patient is under 18 years of age: _____

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CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

CONSENT TO CHIROPRACTIC TREATMENT – FORM L

It is important for you to consider the benefits, risks and alternatives to the treatment options offered by your chiropractor and to make an informed decision about proceeding with treatment. Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body, soft-tissue techniques such as massage, and other forms of therapy including, but not limited to, electrical or light therapy and exercise.

Benefits

Chiropractic treatment has been demonstrated to be effective for complaints of the neck, back and other areas of the body caused by nerves, muscles, joints and related tissues. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility, improve function, and reduce or eliminate the need for drugs or surgery.

Risks

The risks associated with chiropractic treatment vary according to each patient's condition as well as the location and type of treatment. **The risks include:**

- Temporary worsening of symptoms – Usually, any increase in pre-existing symptoms of pain or stiffness will last only a few hours to a few days.
- Skin irritation or burn – Skin irritation or a burn may occur in association with the use of some types of electrical or light therapy. Skin irritation should resolve quickly. A burn may leave a permanent scar.
- Sprain or strain – Typically, a muscle or ligament sprain or strain will resolve itself within a few days or weeks with some rest, protection of the area affected and other minor care.
- Rib fracture – While a rib fracture is painful and can limit your activity for a period of time, it will generally heal on its own over a period of several weeks without further treatment or surgical intervention.
- Injury or aggravation of a disc – Over the course of a lifetime, spinal discs may degenerate or become damaged.
- A disc can degenerate with aging, while disc damage can occur with common daily activities such as bending or lifting. Patients who already have a degenerated or damaged disc may or may not have symptoms. They may not know they have a problem with a disc. They also may not know their disc condition is worsening because they only experience back or neck problems once in a while.
    - Chiropractic treatment should not damage a disc that is not already degenerated or damaged, but if there is a pre-existing disc condition, chiropractic treatment, like many common daily activities, may aggravate the disc condition. The consequences of disc injury or aggravating a pre-existing disc condition will vary with each patient. In the most severe cases, patient symptoms may include impaired back or neck mobility, radiating pain and numbness into the legs or arms, impaired bowel or bladder function, or impaired leg or arm function. Surgery may be needed.

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-
- Stroke – Blood flows to the brain through two sets of arteries passing through the neck. These arteries may become weakened and damaged, either over time through aging or disease, or as a result of injury. A blood clot may form in a damaged artery. All or part of the clot may break off and travel up the artery to the brain where it can interrupt blood flow and cause a stroke.

Many common activities of daily living involving ordinary neck movements have been associated with stroke resulting from damage to an artery in the neck, or a clot that already existed in the artery breaking off and travelling up to the brain.

Chiropractic treatment has also been associated with stroke. However, that association occurs very infrequently, and may be explained because an artery was already damaged and the patient was progressing toward a stroke when the patient consulted the chiropractor. Present medical and scientific evidence does not establish that chiropractic treatment causes either damage to an artery or stroke.

The consequences of a stroke can be very serious, including significant impairment of vision, speech, balance and brain function, as well as paralysis or death.

Alternatives

Alternatives to chiropractic treatment may include consulting other health professionals. Your chiropractor may also prescribe rest without treatment, or exercise with or without treatment.

Questions or Concerns

You are encouraged to ask questions at any time regarding your assessment and treatment. Bring any concerns you have to the chiropractor's attention. If you are not comfortable, you may stop treatment at any time.

Please be involved in and responsible for your care. Inform your chiropractor immediately of any change in your condition.

DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE CHIROPRACTOR

I hereby acknowledge that I have discussed with the chiropractor the assessment of my condition and the treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I hereby consent to chiropractic treatment as proposed to me.

_____ Date: _____ 20____.

Name (Please Print)

_____ Date: _____ 20____.

Signature of patient (or legal guardian)

_____ Date: _____20____

Signature of Chiropractor