ESSENTIAL WELLNESS CHIROPRACTIC & MASSAGE

We are so happy you're here! Please take your driver's license and insurance card to the front desk when you check in.

PRENATAL HEALTH HISTORY FORM

Name: _____ Today's Date: _____

What do you prefer to be called: _____

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

Phone number: _____ Email: _____

Marital Status: Single / Married / Widowed Date of Birth: _____

Employment status: Full time/ Part time / Homemaker

Emergency contact: _____

Emergency contact phone number: _____ Relation? _____

Whom may we thank for referring you? _____

Week of Pregnancy: _____ Due Date: _____

Name of Obstetrician/Midwife: _____

Name of the Practice: _____

Name of Doula: _____ Name of the practice: _____

Please check if any of these pertain to you:

- ☐ Over the age of 36
- ☐ First pregnancy
- ☐ Pregnant with multiples
- ☐ Morning sickness, vomiting, nausea
- ☐ Gestational diabetes
- ☐ High blood pressure
- ☐ Placental dysfunction
- ☐ Swollen feet and/or hands
- ☐ Varicose veins
- ☐ Pubic pain
- ☐ Low back pain
- ☐ Bed rest
- ☐ IVF used
- ☐ Heartburn
- ☐ Indigestion
- ☐ Constipation
- ☐ Breech or transverse baby
- ☐ Leg cramps/restless legs
- ☐ Difficulty sleeping
- ☐ Bladder or kidney infection
- ☐ Pre-eclampsia

- ☐ Premature labor
- ☐ Sciatic pain
- ☐ Neck pain
- ☐ High risk
- ☐ Headache

What type of birth do you intend on having?

- ☐ Vaginal
- ☐ Cesarean
- ☐ VBAC

Where do you intend on having your baby(s)?

- ☐ Home
- ☐ Hospital Name of hospital: _____

Overall pregnancy experience? _____

Have you been treated by a chiropractor before? YES / NO (circle one)

Serious medical conditions and/or surgeries: _____

Have you created a birth plan? YES / NO (circle one)

How many children do you have currently (list ages and names)?

_____

Are you currently taking any medications or supplements (please list)? _____

_____

Have you been vaccinated during this pregnancy? _____

What is your sleep quality (circle one)? Good/ Fair/ Poor How many hours/night? _____

Do you exercise currently (circle one)? YES / NO

What type of exercise and how often? _____

Do you have concerns from a previous pregnancy, labor, birth, or postpartum period that you would like to address during this pregnancy? _____

Are you interested in learning about therapeutic massage? YES / NO (circle one)

Are you interested in learning about therapeutic grade essential oils? YES / NO (circle one)

CONSENT TO TREATMENT:

To the best of my knowledge, this form is accurate and complete. I have disclosed all known health conditions and will inform Dr. Marchman of any changes in my health status at the beginning of future appointments. I agree to discuss my pregnancy as it progresses and I consent to treatment.

Signature: _____ Date: _____

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INFORMED CONSENT TO CHIROPRACTIC TREATMENT

The nature of chiropractic treatment. The doctor will use her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop," such as the noise when a knuckle is "cracked," and you may feel movement of the joint.

Possible risks. As with any health care procedure, complications are possible following a chiropractic manipulation, although extremely rare. These include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves, or spinal cord. Cerebrovascular incident can occur upon severe injury to arteries of the neck, but research has shown no causal relationship between adjustments and stroke. A minority of patients may notice stiffness or soreness after the first few days of treatment.

Probability of risks occurring. The risks of complications due to chiropractic treatment are rare, about as often as complications seen from taking a single aspirin tablet.

Other treatment options. Alternatives to chiropractic care include over-the-counter analgesics, prescription medications, injections, and surgery, all of which have their own associated risks.

Risks of remaining untreated. Delay of treatment carries risks as well, and can complicate the condition and make future rehabilitation more difficult. It allows formation of adhesions, scar tissue, and other degenerative changes. These changes can further reduce skeletal mobility and induce chronic pain cycles.

I understand that my doctor at Essential Wellness Chiropractic cannot make any promises or guarantees regarding improvement in my condition. I understand that my doctor will share with me her opinion regarding potential results from chiropractic treatment for my condition and will discuss treatment options with me.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment and hereby give my full consent to treatment.

Printed name: _____ Date: _____

Signature: _____ Witness: _____

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WHAT TO EXPECT AFTER YOUR FIRST ADJUSTMENT

Please keep this form and read the following information carefully.

1. If you have never been adjusted or if it has been awhile since your last adjustment, you may experience soreness or discomfort for a few hours to a few days. This is a normal reaction to chiropractic adjustments.

2. If you experience soreness, use ice on the affected area. Ice therapy consists of the use of ice packs at 20 minute intervals followed by 20 to 40 minutes of rest. This can be repeated as often as needed. Always protect the skin with a thin covering such as a shirt or thin towel.

3. Do not use heat except under Dr. Marchman's instruction. Heat may aggravate your injury.

4. Avoid heavy lifting for at least 24 hours after your adjustment.

5. Take caution when performing strenuous athletic activities such as running, lifting weights, tennis, high impact sports, as well as yard work or house work that may aggravate your condition. We believe activity is a good thing and our goal is to get you back to feeling 100% as soon as possible. We want you to be active as your body heals, but also know when you need to slow down.

6. Unless indicated by Dr. Marchman, you may return to school or work after your appointment.

7. Drink plenty of water for 24 hours after your adjustment.

8. If a sudden movement causes a sharp or severe pain or if you experience swelling, contact our office at 470-522-7801.

Please visit our website at www.drmarchman.com and LIKE us on Facebook at www.facebook.com/essentialwellnesschiropractic for news and updates about our office.