# *New Pregnant Patient Self-Assessment*

***Winchester Hospital Chiropractic Center***
300 Trade Center, Suite 4460
Woburn, MA 01801
781.933.5051
www.winchesterhospitalchiro.com

Patient's Full Name:_____ Nickname_____ Occupation:_____

Your Email If You Want To Receive Our Monthly Newsletter_____ Do you Smoke?_____

Primary Care Physician:_____ If So, How Much_____

Their Address:_____ Do You Exercise?_____

Ob/Gyn Or Midwife:_____ If So, How Much?_____

Their Address:_____ How Far Along Are You_____

Where Will You Deliver_____ Your Due Date_____

I Was Referred By:_____ Right / Left Handed

Reason For Today's Visit:_____ Height_____ Weight_____ Age_____

List Any Medications You Are Taking_____ Today's Date_____

**HEAD, NECK, BACK, EXTREMITIES Check symptoms you currently have or have had in the past year.**

| **HEAD** | **Left** | **Right** |
|---|---|---|
| ☐ Headaches | ☐L | ☐R |
| ☐ Migraines | ☐L | ☐R |
| ☐ Face pain | ☐L | ☐R |
| ☐ Jaw pain | ☐L | ☐R |
| **NECK** | | |
| ☐ Pain in neck | ☐L | ☐R |
| ☐ Neck stiffness | ☐L | ☐R |
| ☐ Neck weakness | ☐L | ☐R |
| ☐ Grinding sounds in neck | ☐L | ☐R |
| ☐ Tingling in the neck | ☐L | ☐R |
| ☐ Neck feels out of place | ☐L | ☐R |
| **MIDBACK** | | |
| ☐ Midback pain | ☐L | ☐R |
| ☐ Midback stiffness | ☐L | ☐R |
| ☐ Pain between shoulder blades | ☐L | ☐R |
| ☐ Muscle spasms in midback | ☐L | ☐R |
| ☐ Midback feels out of place | ☐L | ☐R |
| **LOWER BACK** | | |
| ☐ Pain in lower back | ☐L | ☐R |
| ☐ Lower back stiffness | ☐L | ☐R |
| ☐ Muscle spasms in lower back | ☐L | ☐R |
| ☐ Lower back feels out of place | ☐L | ☐R |
| **SHOULDERS** | | |
| ☐ Pain in shoulder | ☐L | ☐R |
| ☐ Pain across tops of shoulders | ☐L | ☐R |
| ☐ Can't raise arm | ☐L | ☐R |
| ☐ Above shoulder level | ☐L | ☐R |
| ☐ Overhead | ☐L | ☐R |
| ☐ Tingling in shoulder | ☐L | ☐R |
| ☐ Tension in shoulder | ☐L | ☐R |
| ☐ Numbness in shoulder | ☐L | ☐R |

| **ARMS & HANDS** | **Left** | **Right** |
|---|---|---|
| ☐ Pain in upper arm | ☐L | ☐R |
| ☐ Pain in elbow | ☐L | ☐R |
| ☐ Pain in forearm | ☐L | ☐R |
| ☐ Pain in hand/fingers | ☐L | ☐R |
| ☐ Pins/needles feeling in arm | ☐L | ☐R |
| ☐ Pins/needles feeling in finger | ☐L | ☐R |
| ☐ Numbness in arm | ☐L | ☐R |
| ☐ Numbness in hand/fingers | ☐L | ☐R |
| ☐ Weak arm/hand | ☐L | ☐R |
| **HIPS, LEGS & FEET** | | |
| ☐ Pain in buttocks | ☐L | ☐R |
| ☐ Pain in hip joint | ☐L | ☐R |
| ☐ Pain down leg | ☐L | ☐R |
| ☐ Pain in knee | ☐L | ☐R |
| ☐ Pain in ankle | ☐L | ☐R |
| ☐ Pain in foot | ☐L | ☐R |
| ☐ Pain in toes | ☐L | ☐R |
| ☐ Pins/needles in leg | ☐L | ☐R |
| ☐ Pins/needles in toes | ☐L | ☐R |
| ☐ Numbness in leg | ☐L | ☐R |
| ☐ Numbness in foot/toes | ☐L | ☐R |
| ☐ Weakness of leg | ☐L | ☐R |
| ☐ Weakness of knee | ☐L | ☐R |
| ☐ Leg cramps | ☐L | ☐R |
| ☐ Cold feet | ☐L | ☐R |

**OTHER SYMPTOMS:**

_____

_____

_____

_____

_____

**GENERAL SYMPTOMS Check symptoms you currently have or have had in the past year.**

**GENERAL**

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Anorexia/Bulimia
- ☐ Arthritis
- ☐ Bleeding Disorders
- ☐ Cancer/Tumors
- ☐ Chemical Dependency
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting or Seizures
- ☐ Fibromyalgia
- ☐ Forgetfulness
- ☐ Gout
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ Multiple Sclerosis
- ☐ Nervousness
- ☐ Night Sweats
- ☐ Osteoporosis
- ☐ Paralysis
- ☐ Psychiatric Care
- ☐ Stroke
- ☐ Tiredness
- ☐ Thyroid Problems
- ☐ Weight Change (dramatic)

**OTHER SYMPTOMS**

_____

_____

**EYE, EAR, NOSE, THROAT**

- ☐ Blindness
- ☐ Blurred Vision
- ☐ Cataracts
- ☐ Double Vision
- ☐ Floaters/Haloes
- ☐ Glaucoma
- ☐ Earache
- ☐ Hearing Loss
- ☐ Ringing in ears
- ☐ Vertigo (dizziness)
- ☐ Allergies/Hayfever
- ☐ Nasal Drip
- ☐ Nosebleeds
- ☐ Sinus Problems
- ☐ Bleeding Gums
- ☐ Chronic Cough
- ☐ Difficulty Swallowing
- ☐ Slurred Speech
- ☐ Throat Hoarseness

**RESPIRATORY**

- ☐ Asthma
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Mono
- ☐ Emphysema
- ☐ COPD
- ☐ Shortness of Breath

**GASTRO-INTESTIONAL**

- ☐ Poor Appetite
- ☐ Black/Bloody Stool
- ☐ Bloating/Gas
- ☐ Bowel Changes
- ☐ Colitis/IBS
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive Hunger
- ☐ Excessive Thirst
- ☐ Hemorrhoids
- ☐ Hernia
- ☐ Indigestion
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Loss of bowel control
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Reflux
- ☐ Stomach Pain
- ☐ Ulcers
- ☐ Vomiting
- ☐ Weight Trouble

**CARDIOVASCULAR**

- ☐ Chest Pain
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Irregular Heartbeat
- ☐ Low Blood Pressure
- ☐ Pacemaker
- ☐ Poor Circulation
- ☐ Swelling of Ankles
- ☐ Varicose Veins

**GENITO-URINARY**

- ☐ Bladder Trouble
- ☐ Difficulty starting flow
- ☐ Difficulty stopping flow
- ☐ Frequent Urination
- ☐ Incontinence
- ☐ Milky/Bloody Urine
- ☐ Painful Urination

**GYN**

- ☐ Abnormal Pap Smear
- ☐ Abnormal Periods
- ☐ Breast Lumps/Pain
- ☐ Cysts/Tumors
- ☐ Discharge
- ☐ Dysmenorrhea
- ☐ Endometriosis
- ☐ Extreme Cramps
- ☐ Hot Flashes
- ☐ Spotting

Have you had a Mammogram?

**SKIN**

- ☐ Bruises Easily
- ☐ Changes in Moles
- ☐ Eczema/Psoriasis
- ☐ Hives/Rash
- ☐ Itching
- ☐ Skin Cancer
- ☐ Sores not healing

If you have a family history of any medical problems, please list them:_____

How would you say the pregnancy is going so far_____ Names and ages of current children_____

Have you ever seen a chiropractor before_____ Have you had any injuries during this pregnancy (accidents, falls, etc.)?_____

Any treatment required during this pregnancy (chiro., PT, massage, etc.) _____

Any health problems during this pregnancy (diabetes, pre-eclampsia, bed rest, etc.)_____

Have you been told your baby is in a breech position?_____ If so, what have you tried_____

**I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of the staff responsible for any errors or omissions that I may have made in the completion of this form.**

**Signature**_____ **Date**_____