



Advanced Health Solutions

Kyle Lopez D.C. & Renee Lopez D.C.

401 North Section St
Fairhope, Alabama 36532
P 251-928-5058

youradvancedhealthsolutions.com

Pregnancy

Wellness Profile



Practice Member Information

File _____

Name: _____

Appointment Date M _____ D _____ 20 _____ Birth Date M _____ D _____ Y _____

Home Address: _____

City _____ State _____ Zip _____

Home Phone: _____ May we leave a message? Yes No

Cell Phone: _____ May we leave a message? Yes No

Work Phone: _____ May we leave a message? Yes No

Email: _____

May we add you to our email newsletter and calendar of events? Yes No (Your email will not be shared)

Spouse's name? _____

Name(s) and age(s) of children: _____

Occupation: _____

Do you primarily: Sit Stand Perform repetitive tasks

How did you hear about us? _____

Healthcare History

Have you had previous chiropractic care? No Yes

Who was your previous Chiropractor? _____

Where? _____ When? _____

Were X-rays taken in the last 6 months? Yes No

What was the primary reason for consulting that office?

Relief Care - Symptom relief of pain or discomfort

Corrective Care - Correcting, relieving and stabilizing spinal, joint and postural issues

Wellness Care - Maximizing the body's ability for optimal healing and function

Do you feel your previous chiropractic care was effective? No Yes

Please explain: _____

Are you wearing: Heel Lifts Custom Orthotics

Family Doctor: _____

Date and reason of last visit: _____

May we contact your family doctor regarding your care at our office if necessary? No Yes

Naturopathic Doctor: _____

Date and reason of last visit: _____

Other Specialists and healthcare professionals:

Name: _____

Professional Designation: _____

Date and reason of last visit: _____

Name: _____

Professional Designation: _____

Date and reason of last visit: _____



Pregnancy Profile

How far along in your pregnancy are you? _____ When is your baby's due date? D ____ M ____ Y ____

Have you taken any medications during this pregnancy? No Yes:

OTC and Reason: _____

Prescription and Reason: _____

Vaccines and Reason: _____

Have you experienced any physical trauma during this pregnancy? No Yes _____

Have you had any evaluation procedures (ultrasound, amniocentesis, chorionic villus sampling)? No Yes

Dates and Reasons: _____

Have there been any stressful events in your life during this pregnancy? No Yes _____

What type of birth care provider are you planning on using? Midwife OB/Gyn Medical Doctor Other

Where do you plan on delivering? _____

Is this your first pregnancy? Yes No:

If not, how many pregnancies previously? _____

How many children do you have? _____

Miscarriages? No Yes: D&C Natural Miscarriage

How many vaginal deliveries? _____

How many caesarean sections? _____

Have there been any complications during your previous deliveries? No Yes _____

Was labor induced/use of Pitocin? No Yes Unknown

Did your care provider rupture your membranes? No Yes Unknown

Was there any back or hip pain during labor? No Yes

Was baby in a suboptimal position during the pushing phase of any labor? No Yes Unknown

Did you receive an epidural? No Yes

Were there any operative devices used? No Yes Forceps Vacuum

Any postpartum complications or long term consequences? No Yes _____

Have you experienced any of the following symptoms during this pregnancy or a previous pregnancy?

CURRENT PREVIOUS

- Headaches
Facial Paralysis
Chronic Fatigue
Nausea/"Morning Sickness"
Heartburn/Indigestion
Preeclampsia
Gestational Diabetes
Constipation
Hemorrhoids

CURRENT PREVIOUS

- Carpal Tunnel (numbness in hands/fingers)
Low/Mid Back Pain
Breech or Sidelying Presentation
Round Ligament Pain/Pulling (front of belly)
Pain in your Pubic Bone
Pins/Needles in the Front/Side of your Leg
Pain in Posterior Leg (Sciatica)
Leg Cramps
Swelling of Ankles, Legs and Feet



Wellness Profile

Do you have a specific concern that brings you in?

No, I'm interested in having my spinal and pelvic alignment assessed to help achieve optimal growth and delivery for my baby

Yes:

If yes, please answer the following questions:

What is your primary area of complaint today?

How long have you been aware of this? days weeks months years

Where else does this pain go in your body?

How often do you experience this? daily weekly monthly comes and goes constantly

On a scale of 1 to 10 (10 being the worst), how does it feel when it's at its worst?

How would you describe the pain/discomfort?

Dull Achy Throbbing Stabbing Tight/Stiff Burning Sharp Other

What makes it feel worse?

What makes it feel better?

Do you notice any other problems in your body when you get this pain/discomfort?

Do you feel your condition getting progressively worse? No Yes

Do you feel your condition can be healed? No Yes

What have you tried that has helped? Ice Heat Medication Massage Physical Therapy Chiropractic

Other

What have you tried that hasn't helped? Ice Heat Medication Massage Physical Therapy Chiropractic

Other

See additional Spinal Nerve Function Form to provide further detail on your Wellness Profile (Page 6)

Lifestyle Information

The human body is designed to be healthy. The primary system in the body which coordinates health and function is the nervous system. Your nervous system is surrounded and protected by the bones of the spine, called vertebrae. Physical, emotional, and chemical stresses, common to our contemporary lifestyle, can result in misalignment to the spinal column as well as damage the delicate nervous system. The result is a condition called a Vertebral Subluxation. The remainder of the intake form addresses the possible factors which may contribute to vertebral subluxation in your spine which may be impeding your body's ability to heal.

Physical

Height Weight

Are you happy with your current physical appearance and abilities? Yes No

Frequency of exercise/week: Cardio? 0 1 2 3 4 5 6 7

Weight bearing? 0 1 2 3 4 5 6 7

Do you stretch after exercise or after other activities of poor posture? Yes Sometimes No

Hours of sleep/night? <6 7-9 10+

Do you feel refreshed upon waking? Always Sometimes Rarely

Age of mattress? Do you feel your mattress is appropriate for your sleeping style? No Yes

Which position do you sleep? Back Belly Side: Right Left Both

Number of hours spent commuting/week? 0-2 3-5 6-8 9-11 12+

Number of hours spent at a desk or computer/week? 0 1-5 6-10 11-20 21-40 41+

Number of hours spent on smart device/tablet/week? 0 1-5 6-10 11-20 21-40 41+

Do you perform any repetitive tasks at home or at work? No Yes

Have you ever been hospitalized or had surgery? No Yes If yes why and when?

Have you ever been in a motor vehicle accident (even if it was minor)? No Yes

If yes, what kind and when?

Were you evaluated and treated after each accident? No Yes

Have you had any non-vehicle accidents or falls? No Yes



Early Years

To your knowledge, was your delivery difficult? No Yes
If yes: Forceps Vacuum Caesarean Breech Other
Were you breast fed? No Yes For how long?
Did you experience emotional trauma as a child? No Yes
Were you ever given antibiotics as a child? No Yes
Did you ever have ear infections as a child? No Yes
Any major childhood illness? No Yes

Emotional

Rate your current level of personal stress in your life: None Low Moderate High
Rate your current level of relationship stress in your life: None Low Moderate High
Rate your current level of financial stress in your life: None Low Moderate High
Rate your current level of health stress in your life: None Low Moderate High
Rate your current level of family stress in your life: None Low Moderate High
Rate your current level of career stress in your life: None Low Moderate High
Do you feel you have a supportive network of friends and family? Yes No
Do you feel you have healthy coping strategies for life stress? Yes No

Chemical

Were you vaccinated as a child? No Yes
Any adverse reactions to vaccines? No Yes
Do you choose to have annual flu shots? No Yes
Do you take antibiotics? No Yes, How often?
How many glasses of water/day: 0 1-3 4-6 7-9 10+
How many glasses of caffeinated beverages/day: 0 1-3 4-6 7-9 10+
How many glasses of cow's milk, juice and pop/day: 0 1-3 4-6 7-9 10+
Do you eat gluten? No Yes Trying to eliminate from diet
Do you eat dairy? No Yes Trying to eliminate from diet
Do you eat refined sugars? (white sugar, white bread and pasta) No Yes Trying to eliminate from diet
Do you eat boxed/frozen foods? No Yes Trying to eliminate from diet
Do you choose organic foods? No Yes, which: Veggies Fruits Meats Grains All
Do you eat any artificial sweeteners? (Splenda, Aspartame, Diet Soda, etc) No Yes
Any food/drink allergies, sensitivities, intolerances? No Yes
Do you smoke? No Yes I used to for__ years I wish I didn't
Are you or have you been exposed to second hand smoke? No Yes
Do you drink alcohol? No Yes 0-6/week 6-12/week 12+/week
Do you take a probiotic daily? No Yes, CFU's/day
Do you take vitamin D3 daily? No Yes, IU's/day
Do you take Omega 3 Fish Oils daily? No Yes, mg/day Capsule Liquid
Other supplements or homeopathics?
Any other daily medication and their purpose?

Do you have a plan in place with your medical doctor to wean yourself off of any long term medications? No Yes



Family Health

At our clinic we are not only interested in your health and wellness, but also the health and wellness of the important people in your life. Please mention below any health conditions or concerns you may have about your:

Children: _____

Spouse: _____

Mother: _____

Father: _____

Brothers/Sisters: _____

Are you seeking chiropractic care today for:

Relief Care - Symptom relief of pain or discomfort

Corrective Care - Correcting, relieving and stabilizing spinal, joint and postural issues

Wellness Care - Maximizing the body's ability for optimal healing and function of the nervous system

Pregnancy Care: regular care throughout pregnancy to optimize the growth and development of my baby and prepare my body for a healthy delivery and fast recovery.

Do you have other concerns we should know about? _____

Goals & Consent

What is your primary goal for consulting our clinic? _____

Our goals are to provide a detailed assessment of your current health status and provide to you the resources for a highly engaged and healthy body which is functioning at its absolute peak potential. Essential to this is a healthy nervous system functioning free from interference called subluxations. You've taken an important step for your health through a chiropractic evaluation!

Consent to Evaluation

I _____ hereby grant permission to receive a chiropractic evaluation including history, spinal scan and examination. Any findings will be communicated before consenting to commencement of care, if appropriate.

Consenting Adult's Signature

Date

SPINAL NERVE

ORGANS & GLANDS

The organs and glands listed below are linked to the corresponding sections of the spine and it's spinal nerves.

ASSOCIATED SYMPTOMS

Please indicate below any symptoms you are currently experiencing as well as any you have previously experienced.

SPINAL NERVE	ORGANS & GLANDS	ASSOCIATED SYMPTOMS				
		CURRENT	PREVIOUS			
C E R V I C A L C1 C2 C3 C4 C5 C6 C7 C8	Parotid Gland • Scalp Base of Skull • Eyes Lacrimal Gland • Sinuses Inner, Middle & Outer Ear Nose • Mouth Intracranial Blood Vessels Sympathetic Nervous System Neck Muscles • Diaphragm Shoulders • Elbows • Arms Wrists • Hands & Fingers Tonsils • Vocal Cords Esophagus • Heart Lungs • Chest • Thyroid	Sinus & Ear Pain/Infection Runny Nose & Allergies Frequent Head Colds Sore Throat & Tonsillitis Strep Throat Chronic Cough & Croup Difficulty Breathing Poor Immunity Dizziness & Vertigo Tinnitus & Ear Fullness Vision Problems Watery/Dry Eyes Chronic Fatigue Poor Concentration Depression	Anxiety & Stress Seizures ADD/ADHD Thyroid Dysfunction Metabolic Dysfunction Insomnia High/Low Blood Pressure Enlarged Lymph Glands Migraines & Headache TMJ Pain Stiff Neck Arm Pain Hand/Finger Numbness Loss of Grip Strength			
	T H O R A C I C T1 T2 T3 T4 T5 T6 T7 T8 T9 T10 T11 T12	Arms • Wrists Esophagus • Chest • Heart Lungs • Trachea • Larynx Diaphragm • Stomach Gallbladder • Liver Pancreas • Small Intestine Spleen • Kidneys • Appendix Adrenals • Colon • Buttocks Uterus • Ovaries • Testes	Asthma Bronchitis & Pneumonia Congestion Reflux & GERD Indigestion & Heartburn Stomach Pains Ulcers Gas & Bloating Jaundice Liver Conditions Blood Sugar Dysregulation	Kidney Stones Gall Bladder Attacks Skin Conditions & Rashes Menstrual Cramps/PMS Infertility Menstrual Dysfunction Rashes & Eczema Hyperactivity Shoulder Pain Midback Pain Rib Pain		
		L U M B A R L1 L2 L3 L4 L5	Large Intestine • Colon Thighs • Buttocks • Groin Knees • Legs • Feet Reproductive Organs	Irritable Bowel, Colitis, Crohn's Gas Pain & Constipation Diarrhea Hemorrhoids Bladder Infections Bladder Incontinence & Bedwetting Painful/Excessive Urination	Prostate Dysfunction & Impotence Ovarian Cysts & Endometriosis Fertility Problems/ Loss of Menstruation Low Back Pain Hip Pain Thigh Pain Numbness & Tingles in Legs	
			S A C R A L S1 S2 S3 S4 S5	Buttocks • Groin • Legs Ankles • Feet • Toes Prostate Gland • Bladder Reproductive Organs	Varicose Veins Leg Cramping Restless Legs Poor Circulation & Cold Feet	Sciatica Pelvic Pain Knee Pain Ankle Pain & Sprains Foot Pain & Weak Arches