Clinic - Case No________ Chiprorpractor _____________________ Date:____________

Pregnancy specific

Name: ………………………………………………..……………………………………Date of Birth:…………………………….…..……

Address: ………………………………..…………………………………………………………..……………..………….………………..…….

…………………………….………………….………....……………………..……….. Post Code……………………………..…….….……..….

Please indicate with a tick your preferred method of contacting you with respect to your appointments:

☐ Telephone (Home): ……………………..…………………….…....…….. ☐ Telephone (Work): ……..……………….…………………..…….……

☐ Telephone (Mobile): ………………………………………………….... ☐ E-Mail Address:………………..…………..….…………………

G. P. Name & Address: ……………………………..……………..…………………………………………………………………...………………

Occupation:……………………….…….…..…………………….…Do you have any health Insurance………………………………………….………

Height:………………………Weight………………………… Marital Status: M Partner S D W

Due Date _______________ Weeks of gestation _________________________Midwife _____ _____________________________________

Medications ______________________________________Nutritional supplementation ____

Diet – including any restriction/special diet ____

Any recent infections? Y N Urinary tract __________ COVID __________ Strep ________________ Other______________,

When did you last have your BP checked? ______________________ __________ what was it? ____________________________________

History of LBP (prior to or during a previous pregnancy) ____

Previous trauma to the pelvis __________________________________ Multiples pregnancy (twins, etc.) ____________________________

Pelvic floor muscle dysfunction _______________________________Diastisis Recti ____

Weight gain during pregnancy ____________________________ Gestational diabetes test results (~20 weeks) ________________________

Recent Headaches ___________________Migraine HA_________________ Pattern____

Back pain/Pelvic Girdle Pain Y N if yes, what trimester or week did the pain start? ___________________________________

Which movements provoke your pain? Bending over, lean backwards, rotation, side bending? ____

Do you have any pain going into the leg? If yes, where and does it go past the knee? ____

How would you rate your pain on a scale of 1 to 10 (10 being worst ever experienced, 1 being a little)

VAS: 1 2 3 4 5 6 7 8 9 10

What improves your pain? (i.e. position, treatment, etc.). ____

Describe or explain the character of your pain? Achy; sharp; dull; stabbing; stiff; tight?

Are you experiencing any numbness or tingling into the legs or feet? Y N If yes, constant? Y N

Are you experiencing any numbness or tingling into arms or hands? Y N If yes, constant? Y N

What movements provoke your pain? For example:

Is pain provoked by prolonged standing, Y N walking Y N sitting? Y N

Is pain provoked by turning over in bed? Y N putting on footwear? Y N

Is pain provoked getting in or out of the car? Y N

What, if any, activities of daily living are limited because of the pain? For example:

Bending over to tie your shoe Y N - Climbing stairs Standing on one leg Y N

Caring for a child in your home? Y N - Is there pain with vaginal intercourse? Y N

Are you having difficulty controlling your bladder or bowels? Y N Has this changed since being pregnant? Y N

Do you leak when you sneeze, cough, jump or run? Y N

Clinic - Case No_____ Chiropractor _____ Date:_____

Have you had any recent medical treatment / scans / x-rays?: Y N _____

Have you had any falls or accidents? Y N Have you had any traffic accidents? Y N

Have you had any operations? Y N Any known allergies?: Y N if yes, which ones?_____

Do you have to carry an Epi-Pen? Y N

Do you smoke? Y N How many units of alcohol do you drink per week? ……..

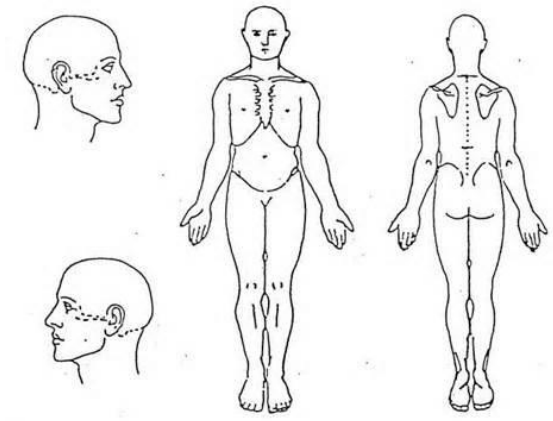
Which exercises/sports do you do? ……How often?……

How has your pregnancy been? (fatigue, nausea, bleeding) _____

Do you or any family member have any of the following illnesses?

Dizziness/Fainting	Y	N	Family member ☐	Bladder/Kidney	Y	N	Family member ☐
Tinnitus/Deafness	Y	N	Family member ☐	Reproductive System	Y	N	Family member ☐
Ear/Nose/Throat	Y	N	Family member ☐	Diabetes	Y	N	Family member ☐
Teeth/Jaw pain	Y	N	Family member ☐	Cancer	Y	N	Family member ☐
Asthma/Lung	Y	N	Family member ☐	Epilepsy/MS	Y	N	Family member ☐
Heart/Stroke	Y	N	Family member ☐	Sleeping problems	Y	N	Family member ☐
Blood pressure	Y	N	Family member ☐	Depression/Anxiety	Y	N	Family member ☐
Stomach/Bowel	Y	N	Family member ☐	Chronic Fatigue	Y	N	Family member ☐
Liver	Y	N	Family member ☐	Painful periods	Y	N	Family member ☐
Hypermobility	Y	N	Family member ☐	Breast problems	Y	N	Family member ☐
Lupus/Rheumatoid	Y	N	Family member ☐	Fertility issues	Y	N	Family member ☐
				Broken bones	Y	N	Family member ☐

Please mark on this chart where you feel pain, tingling or numbness currently?



Consent form *– please read, initial each consent part and sign and date at the bottom. Please note that you do not have to sign the consent to treatment before you have discussed your condition and treatment options with the chiropractor.*

Examination:

I hereby give my consent to the chiropractor performing a physical exam.

Initials_____

GP Referral:

I give my consent for the clinic to contact my GP or midwife in case of emergency or if clinically indicated.

Initials_____

Data Protection:

Under the GDPR (2018) regulations we are required to advise you of our Data Protection Policy which is available in full by request or on our website. We process your data in lawful and transparent manner. We only gather information that we need, it will always be available to you free of charge and it is securely stored. As part of the patient record, this clinic is required to retain information for the purpose of consultation, for treatment, recording subsequent treatments and for the use by third party medical practitioners only at the request of the patient in writing. Upon completion of this form all paper files and electronic records will be kept for as long as the patient remains a patient of the clinic and thereafter for a period of 7 years. All information is confidential and will not be given to any person or organisation without the written consent of the patient concerned. All data is held either electronically or on paper in files accessible only by clinic staff who are directly involved in the data entry and processing of patient records.

I give my consent to the clinic to maintain my records for the purpose outlined as above.

Patient Signature _____ Date_____

Clinic - Case No_____ Chiropractor _____
Date:_____

PRIMARY COMPLAINT

PGP Risk factors:

History of LBP
Previous trauma to the pelvis
High number of pain provocation tests
Multiples pregnancy (twins, etc.)
Polyhydramnios
LGA foetus
Pelvic floor muscle dysfunction
Work dissatisfaction
Depression/anxiety/stress

Diet/Lifestyle factors

Positioning of baby

Physical activity

Hypermobility

Previous pregnancies

IVF

Postpartum complications

Red Flags
Bleeding
Hypertension
Sudden onset Headache
Itching
Face swelling
Anxiety/depression
Contractions
Fever/Infection
Changes in vision
Sudden change in foetal movement

General Medical History

Summary:

ADMIN notes: *HVLA SMT **contraindicated** in EDS [WHO guidelines 2005]*

Fundal Height Measurement

Urinalysis: Date: Proteinuria Blood Ketones Other

Clinic - Case No_____ Chiropractor _____

Date:_____

VITAL SIGNS:

BP_____

PULSE: _____

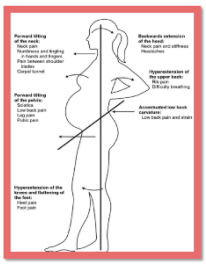
TEMP: _____

RESP: _____

General Obs

Eyes
ENT
SKIN
RASH
Abdomen orientation
TONICITY

Posture



Cranial Nerves:

		L	R			L	R
I	(smell)	___	___	VIII	(hearing)	___	___
II	(acuity,field,fundus	___	___	IX	(taste,gag)	___	___
III, IV, VI	(LR6,SO4, pupil)	___	___	X	(phon)	___	___
V	(sens,bite, corn refl,TMJ)	___	___	XI	(SCM, Trapz)	___	___
VII	(musc, taste)	___	___	XII	(musc, taste)	___	___

Frontal
Parietal
Temporal
Occiput
Sphenoid
Palate/Vomer
Facial Vault

Teeth/Gums
TMJ
Eyes
Ears
SCM
Hyoid
Mandible

Extremities: *(Palpation / ROM / Bursa / Ligament / Tendon / Muscular)*

Shoulder:
Pain arc - ROM
Scap - Hum rhythm
Flex - (Delt Coracobr)
Ext – (Delt / Lat Dorsi/ Teres Maj)
Add – (Lat Dorsi / Pec Maj)
Abd – (Delt / Supraspin)
Int Rot (Subscap/T Maj/ Lat dorsi)
Ext Rot – (Infraspin/ T Minor)

Elbow:
ROM
Biceps
Triceps
Wrist Flexors
Wrist Extensors

Wrist/Hand:
ROM
Grip
Opposition

Hip
ROM
Thomas
Piriformis
Quads
Hamst
Adductor
Fabers

Knee
ROM
Compress/distract
Lat Lig/Med Lig
Med/Lat Meniscus
Patella
Drawer's
McMurray's

Ankle/Foot
ROM
Eversion
Inversion
Dorsi-flexion
Plantar flexion

_____

Other

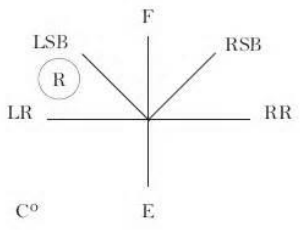
Beighton Score

Urinalysis

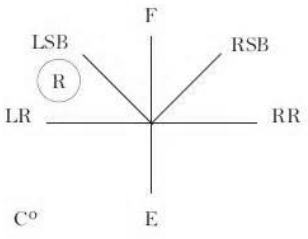
Plantar arch

Clinic - Case No_____ Chiropractor _____
Date:_____

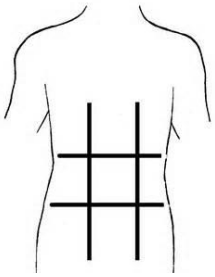
Cervical ROM



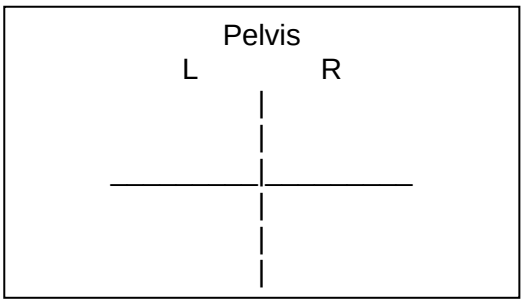
Lumbar ROM



Abdomen



Segmental Palpation	Pain	Reflexes	Strength L	Strength R
__Occ__	Temporalis	C5 (Delt)	/5	/5
__ C1__	Masseter	C6 (Biceps)	/5	/5
__ C2__	Pterygoids	C7 (Wrist flex)	/5	/5
__ C3__	Suboccipitals	C8 (Wrist ext)	/5	/5
__ C4__	Post / Ant Scalenes	T1 (finger flex)	/5	/5
__ C5__	SCM	L4/5 (Patella)	/5	/5
__ C6__	Trapz (Up/Mid/Low)	L5/S1 (Achilles)	/5	/5
__ C7__	Lev Scap	Babinski		
__ T1__	Pec Major/Minor	Clonus		
__ T2__	Rhomboids			
__ T3__	Supraspinatus			
__ T4__	Infraspinatus			
__ T5__	Teres Minor			
__ T6__	Subscapularis	**Short Leg:**	**Prone** L R	**Supine** R L
__ T7__	Deltoid			
__ T8__	Lat Dorsi			
__ T9__	Deep Paraspinals			
__ T10__	Quad Lumb			
__ T11__	Glutei (Max/Med/Min)			
__ T12__	Piriformis			
__ L1__	Ileo-Psoas			
__ L2__	Adductors			
__ L3__	TFL			
__ L4__	Hamstrings			
__ L5__	Quads			
__ S1__	Gastroc/Soleus			
	Tib Ant/ Peroneus			



Orthopaedic Tests:

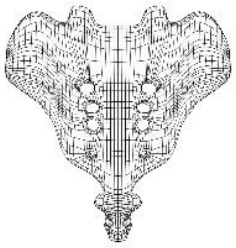
Cx Mobility
VBAI
Axial Comp
Max Foraminal
TOS
Tx Mobility

Pregnancy:
Faber's
Sacrum
Trendelenberg
Pubic Symphysis
Ligamentous palp
Sacro-tuberous lig
Post pain provocation

Gait: Norm Antalgic Neurol

Active SLR R + Dorsiflex
L + Dorsiflex

Lx Mobility
Supported Flex
Valsalva
SI Comp
Hibbs
Yeoman's
Kemp's
Gillets
Gaenslen's
Nachlas
Hyperflex knee Supine / Prone
Sacral Flex / Ext
Gaenslen's
SP Spring + Percussion



Clinic - Case No_____ Chiropractor _____

Date:_____

CASE SUMMARY & CARE PLAN

- Presenting Complaint

- Co-morbidities & relevant medical history

- Rationale for Dx & Rx

- Clinical Impression

- Differential Diagnosis

Any Rx Contraindications or patient preference?

Red/Yellow Flags

- Additional Actions Required

Optimal Foetal Positioning

PGP Questionnaire

- Plan of Management
- *Est number of Rx*
- SMT
- STW
- Cranial/ CST

Self-Management and Patient Education. Pain management, normal activities, specific exercises, advice on postural alignment, core strengthening, stretching, proprioceptive training, advice on positioning and goal setting:

- Patient Goals E.g. Pain Reduction / ADL _____

- Prognosis Good Moderate Poor

- Review Date

Advice/Exercises/hand-outs given

NP info ☐
Care response ☐
Disc Care ☐
Ice/Heat Application ☐
Disc Care ☐
Exercises given

Other _____☐
Colic/Reflux/Positioning ☐
Pregnancy / PGP ex ☐

Report of Findings:

Dietary advice:_____
Sick Note given _____(date)
Further Medical reports_____(date)
Referral:_____
Ergonomic advice_____
Other options of care discussed: (e.g. medical/physical therapy/other CAM)_____
_____
_____
Does patient understand the diagnosis?_____
Have you discussed risks of Rx?_____
_____
Have you discussed prognosis? Yes No

Consent to *Treatment:*

I have been given a verbal report of findings regarding my condition. I have been advised of and understand the benefits and risks of chiropractic treatment and have had all my questions answered to my satisfaction. I hereby consent to treatment as outlined to me.

Patient Signature _____ Date: _____

Clinic - Case No_____ Chiropractor _____
Date:_____

Patient Name *Age*	*Chiro:*
1	*DC* *Next appt*
2	*DC* *Next appt*
3	*DC* *Next appt*
4	*DC* *Next appt*
5	*DC* *Next appt*
6	*DC* *Next appt*

Clinic - Case No_____ Chiropractor _____
Date:_____

Patient Name *Age*	*Chiro:*
7	*DC* *Next appt*
8	*DC* *Next appt*
9	*DC* *Next appt*
Case Review	
10	*DC* *Next appt*
11	*DC* *Next appt*
12	*DC* *Next appt*

Clinic - Case No_____ Chiropractor _____
Date:_____

Patient Name	*Age*	*Chiro:*
13		*DC* *Next appt*
14		*DC* *Next appt*
15		*DC* *Next appt*
16		*DC* *Next appt*
17		*DC* *Next appt*
18		*DC* *Next appt*
19		*DC* *Next appt*