Name _____

Date of Birth _____

Address _____

City_____ State_____ Zip_____

Phone _____ Email _____

Emergency Contact _____ Phone _____

GREEN KEY HAVEN
chiropractic and bodywork

GESTATION HISTORY

Length of Pregnancy (# weeks) _____

How did your mother feel during pregnancy?

_____

Did any of the following occur during pregnancy? (circle and explain below)

accidents new diagnosis medications none

_____

_____

POST-NATAL HISTORY

Use the section on bottom left to clarify answers

Were you in intensive care as a newborn? Y / N

Were you blue after delivery? Y / N

Did you struggle with breastfeeding? Y / N

Did you spit up frequently as a baby? Y / N

Did you have colic? Y / N

Did/do you have regular bowel activity? Y / N

Did/do you have strabismus? Y / N

Do you struggle with sleep, past or present? Y / N

Have you had vaccinations? Y / N

Do you receive other holistic/alternative care? Y / N

If so, who and how often? Y / N _____

_____

_____

LABOR/ DELIVERY HISTORY

How long was labor? _____

Time spent pushing? _____

Was your mother induced? _____

Methods of pain control used? _____

Your presentation at birth? (circle)

Normal Breech Posterior Transverse

What type of delivery did you have? (circle)

Vaginal Cesarean Section

Were forceps or vacuum suction used? Y / N

Did you breathe on your own? Y / N

Concerns with the umbilical cord? Y / N (circle)

loosely wrapped tightly wrapped knotted

Where was it wrapped? _____

APGAR scores (if known) _____

_____

_____

_____

_____

_____

_____

_____

DIET

As an infant? Breast Formula

Currently? Dairy-free Vegetarian/Vegan Gluten-free No Restrictions

Other _____

PRIORITY CONCERNS _____

_____

_____

_____

_____

_____

MEDICATIONS _____

_____

_____

_____

_____

HOSPITALIZATIONS or SURGERIES _____

_____

_____

_____

_____

PLEASE READ AND INITIAL THE FOLLOWING AND SIGN AT THE BOTTOM

_____ I consent to receive Gillespie Approach by a Licensed Practitioner

_____ I consent to receive chiropractic care by Jake Chambers DC

_____ I understand Jordan Chambers LMT cannot diagnose or treat conditions

Signature _____ Date _____

Practitioner _____ Date _____