EnVitality Wellness Center, LLC
Dr. Jacqueline L. Berens, DC
www.EnVitalityWellness.com

PLEASE NOTE:
This file must be saved to your desktop before and after completing!
Email completed PDF to ***englewood@twwclinics.com***

Personal Information

Date: ________________ **How were you referred to the office?** ____

Name: ____

Date of birth: ____________ **Age:** _____

Address: ____ **City:** ____________________ **State:** ______**Zip:**_________

Home Phone: (____)____________ **Cell Phone:** (____)____________ **Work Phone :** (____)_____________

E-mail: ____

Would you like join our email list to receive monthly health tips, office updates, and more? ☐ **Yes** ☐ **No**

Please note that your email will be exclusively used by EnVitality Wellness Center, LLC and will not be disclosed to any third parties.

Marital status: ☐Single ☐Married ☐Widowed ☐Divorced **Spouse/Partner:**____________________________

Occupation: _____________________________ **Employer:** ____

Names & Ages of Children (Optional):

____

Health History

What is your EnVitality Rating? *(How healthy do you feel when compared to other pregnant women?)*
Please circle: 0 Not Very Healthy, 10 Very Healthy
0 1 2 3 4 5 6 7 8 9 10

What brings you to the office today?

____
____
____
____
____
____

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Current Pregnancy

Are You Currently Pregnant: ☐Yes ☐No **If yes, how many weeks:**_____wks **Estimated Due Date:** _________

Midwife/Obstetrician Name: ____ **Office Phone:**(____)_______________

Doula Name: ____ **Office Phone:**(____)_______________

Date of Last Appointment: _______________

May we update your birthing professionals regarding your care at this office if needed? ☐ **Yes** ☐ **No**

Pre-Pregnancy Weight: ________lbs **Current Weight:** ________lbs **Height:** ______________

I plan on giving birth at: ☐ **Hospital** ☐ **Home** ☐ **Birth Center** ☐ **Undecided**
Name of Hospital or Birth Center: ____

Have you taken any classes in preparation for pregnancy? ☐Yes ☐No
If yes, what type? ____

Please check all the symptoms that apply to you:

___ Pre-pregnancy diabetes ___ Rh negative ___ Seizures ___ Gestational diabetes
___ Genetic disorder ___ Depression ___ Pre-eclampsia ___ Threatened miscarriage
___ Eating Disorder ___ Early labor ___ Blood disorder/clots ___ Drug Addiction
___ Placental dysfunction ___ Bleeding/cramping ___ Alcoholism ___ Anemia
___ Multiple pregnancy ___ HIV Positive ___ Amniotic fluid leakage
___ Fetal development complications ___ Previous pregnancy complications

Have you experienced any complications during this pregnancy? ☐Yes ☐No
If yes, please describe:____
____

Any medications during this pregnancy, including over the counter medication? ☐Yes ☐No
If yes, please describe:____

Any hospitalizations during this pregnancy? ☐Yes ☐No
If yes, please describe:____

Any fertility treatment? ☐Yes ☐No
If yes, please describe:____

Any traumas during this pregnancy? ☐Yes ☐No
If yes, please describe:____

Any other information about your pregnancy? ____

P: 303-668-2103

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Health and Wellness History

On a scale of 1 – 10, describe your stress level: (1 = none / 10 = extreme)
Occupational: ____________________ **Personal:** ________________________

Are you taking any supplements/vitamins? ☐ Yes ☐ No
If yes, please describe:____

How would you rate your diet? ☐ Good ☐ Fair ☐ Poor

# of meals you eat in an average day: _________

Do you drink beverages with a meal? ☐ Yes ☐ No **If yes, what type:**______________________

Breakfast: What time do you typically eat? ________________________________

Lunch: What time do you typically eat? ________________________________

Dinner: What time do you typically eat dinner? ____________________________

Snacks: What time do you snack throughout the day? _________________________

What foods do you crave? ______________________________________

What foods do you avoid? ______________________________________

Do you tend to eat when you are stressed? ☐Yes ☐No **Emotional?** ☐Yes ☐No **Hormonal?** ☐Yes ☐No

After a meal, do you feel bloated? ☐Yes ☐No **Have gas?** ☐Yes ☐No
Have reflux? ☐Yes ☐No **Feel nauseous?** ☐Yes ☐No

Do you use artificial sweeteners? ☐Yes ☐No

Do you consume caffeine? ☐Yes ☐No **What type?** __________________ **How much per day:**_________

After 32nd Week of Pregnancy

Current Position of Baby: ☐ Head down ☐ Posterior ☐ Breech or malpositioned

Confirmed by: Palpation by: ______________________________ Date: ___________
Ultrasound by: ______________________________ Date: ____________

How long do you believe baby has been in this position? ______________________________

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Prior Pregnancy History

Have you ever had a miscarriage? ☐Yes ☐No **If yes, how many?** ______________________________________

Next to the delivery method please mark the number of previous pregnancies:
Vaginal Delivery _________ Caesarean Section _________ Forceps _________ Vacuum Extraction _________

Anesthesia used? ☐Yes ☐No **If yes, what type?** ____

Have you experienced any complications during your previous pregnancies? ☐ Yes ☐ No
If yes, please describe:____
____

Did you have chiropractic care during your previous pregnancies? ☐ Yes ☐ No

Consent For Care

TERMS OF ACCEPTANCE: I, the patient, have been advised about chiropractic care, and like all types of health care, chiropractic can hold certain risks. While the risk are most often very minimal, in rare isolated cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments. I, the patient, have been advised about deep tissue laser therapy, and like all types of health care, therapy lasers can hold certain risks. The primary safety precaution when using therapy lasers is eye protection. Lasers can pose optical risks if the eye is exposed to the laser light. The therapeutic dose of laser light not in the visible light spectrum and therefore is not visible to your eye. Laser-safe eye protection is provided and must be worn by all individuals within the treatment area to ensure a safe environment.

When a patient seeks chiropractic health care, deep tissue laser therapy, and/or any other service provided in our office and we accept a patient for such care, it is absolutely essential for both Patient and Doctor to be working towards the same health objective. Treatment objectives as well as the risks associated with chiropractic adjustments and all other procedures provided at the EnVitality Wellness Center, LLC, have been explained to me to my satisfaction, all my questions have been answered, and I have conveyed my understanding to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and/or techniques the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care, and agree to hold them harmless of consequences thereof.

AUTHORIZATION AND RELEASE: I, the patient, understand and agree to allow EnVitality Wellness Center, LLC, to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. I understand and agree that I am responsible for all costs of care at the time of service, unless otherwise arranged. My Patient Health Information and my rights concerning these records will be protected according to HIPAA.

Patient's Signature: ____ **Date:** ________________

OFFICE USE ONLY

Dr. Notes:____

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Doctor's Signature: ____ **Date:** _________________________

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