Prenatal Chiropractic Care Plan

Pregnant women go to chiropractors for a variety of reasons. Some go for symptomatic relief of the common complaints of pregnancy. Others are interested in having the cause of their problem corrected and continue care after the birth of their babies. It is my desire to honor your commitment to health and recommend a care plan to help you achieve your healthcare goals.

Full Name _____ _____
First Name **Last Name**

Email _____ ____ ____ _____
Month **Day** **Year**

Health Care Goals

❑ Symptom Care/Relief ❑ Corrective Care ❑ Wellness Care ❑ _____

Chief Complaint

❑ Low back	❑ Upper back	❑ Neck
❑ TMJ dysfunction	❑ Headaches	❑ Sciatica
❑ Carpal Tunnel	❑ Breech baby	❑ Transverse
❑ OP	❑ Backache of Pregnancy	❑ History of Face/Head Trauma
❑ Upper/Lower Extremity Pain/Numbness	❑ _____	❑ _____

Prenatal Care

❑ 2 times/week until baby turns then	❑ 2 times/week until birth then	❑ 2 times/week until stable then
❑ 2-4 times/ month until stable then	❑ 1 time/week until stable then	❑ 2-4 times/ month until 32 weeks then
❑ 1 time/week until birth then	❑ Postpartum check up (@ 2-6 wks)	❑ then continued care as needed postpartum

❑ _____

Additional Therapies

❑ Cranial Sacral Therapy (CST)	❑ weekly	❑ 1-2 times/month	❑ as needed
❑ NeuroEmotional Technique (NET)	❑ weekly	❑ 1-2 times/month	❑ as needed
❑ Raindrop Therapy	❑ weekly	❑ 1-2 times/month	❑ as needed
❑ _____	❑ weekly	❑ 1-2 times/month	❑ as needed

The recommendations in your particular case are based on all of the above information as well as our experience with many other cases similar to yours. You may require more or less treatment based on your particular case. These are estimates only to help you plan your time and finances to adequately attain maximum correction.

I understand that by following the prescribed care plan above, I will have a better chance of achieving my health care goals. If I cannot follow the recommended care plan, I may not get the results I am hoping for.

Signature _____