PREGNANCY INTAKE FORM

Thank you choosing our office. We are committed to providing you and your family with the highest quality of chiropractic care available so that you may heal quickly and enjoy an active and healthy, long life. We will be working together to help you and your family reach your health and lifestyle goals. Regardless of your reason for visiting our office today, our goal is to become your family's trusted provider and resource for living a healthy lifestyle throughout your lifetime.

We look forward to helping you and your family members achieve your health goals.

Date: _____ Referred by: _____

Patient Name: _____ Date of Birth: _____ Age: _____

Phone (Cell): _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Occupation: _____ Years on Job _____ Phone (Work): _____

OBGYN/Midwife: _____

Are You: ☐ Married ☐ Single ☐ Widowed ☐ Divorced Number of Children: _____

Emergency Contact Info: _____

Have you had previous Chiropractic care? ☐ Yes ☐ No Chiropractor's Name: _____

What for: _____ Outcome: _____

HEALTH STATUS & HISTORY

What is your **PRIMARY COMPLAINT** that brings you into our office?_____

_____

When did it **FIRST** begin: _____

Was it gradual or sudden? Is it getting **better or worse?** _____

Is there anything that makes it **better**?_____ **Worse:** _____

Type of pain? ☐ Sharp ☐ Dull ☐ Ache ☐ Burn ☐ Throb ☐ Other

Where did it first begin, and does it travel to any other regions of the body? _____

_____

On a scale where 0 is no pain, and 10 is the worst pain you've ever experienced, rate your CURRENT pain level.

0 1 2 3 4 5 6 7 8 9 10

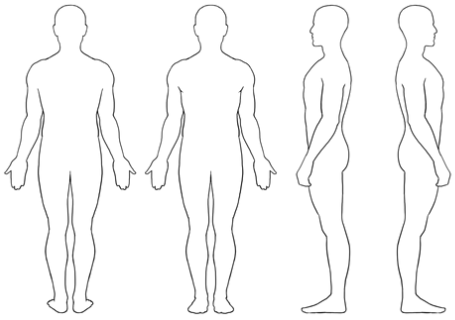
On the same scale, rate your pain at it's LOWEST point.

0 1 2 3 4 5 6 7 8 9 10

At its WORST, how would rate the pain?

0 1 2 3 4 5 6 7 8 9 10

Please mark the location of the problem, if you're having physical symptoms



Stress level overall: ☐ Low ☐ Medium ☐ High ☐ Out of this world

List and describe other health problems

_____

_____

HEALTH STATUS & HISTORY

Is there anything that these conditions keep you from doing: _____

_____

List ALL SURGERIES/PROCEDURES you have undergone (include when it occurred and the outcome):

_____

_____

_____

Prescription medication may cause various side effects, hide the severity of health problems and hinder the body's ability to heal. What medications are you currently taking (prescription and over the counter)?

_____

_____

_____

Injuries can cause serious spinal problems. Have you been injured in the past or recently (sports, work, car accidents, cumulative trauma)? If so, please list and give dates:

_____

_____

_____

Chiropractors are the only doctors trained to analyze, detect and correct Vertebral Subluxations (misaligned vertebrae causing Neurological Dysfunction, thus affecting how your body functions, heals and ages).

Vertebral Subluxations can happen in many ways. Please circle if you have had difficulties with any of the following:

Birth Process (Yours)
Birthing Children (if you're a mom)
Childhood Play
Growth Spurts
Body Weight Changes

Auto Accidents
Work Injuries
Environmental Toxicity
Sports Injuries
Intensive Training

Trips, Falls
Sickness, disease
Other:
_____

HEALTH STATUS & HISTORY

Are you experiencing difficulty with any of the following functions? Please circle Y or N. If Y, please explain

Bladder/Bowel function	Y or N	_____
Sleep	Y or N	_____
Concentration/Focus	Y or N	_____
Energy	Y or N	_____
Digestion	Y or N	_____
Mood	Y or N	_____
Menstrual Cramps	Y or N	_____
Strength/Balance	Y or N	_____
Flexibility	Y or N	_____
Headaches	Y or N	_____
Allergies	Y or N	_____
Posture	Y or N	_____
Blood Pressure	Y or N	_____
Weight Gain/Loss	Y or N	_____
Vision	Y or N	_____
Memory	Y or N	_____
Sexual function	Y or N	_____

As a result of Chiropractic Care, **MY GOALS ARE**:

_____

_____

_____

PREGNANCY QUESTIONNAIRE

Is this your first pregnancy? ☐ Yes ☐ No

If **NO,**

How many children do you have? _____

How many pregnancies previously? _____

How many vaginal deliveries? _____ How many cesarean deliveries? _____

Was labor induced using Pitocin? ☐ Yes ☐ No ☐ Unknown

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

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

Did you receive an epidural? ☐ Yes ☐ No

Were there any operative devices used? ☐ No ☐ Yes ☐ Forceps ☐ Vacuum

Any postpartum complications or long-term consequences? ☐ No ☐ Yes _____

_____

_____

Any other details you would like to provide?

_____

Do you plan to follow the same plan as your previous delivery? ☐ Yes ☐ No

If not, what would you like to change?

_____

_____

If **YES,**

When is your calculated due date? _____ How many weeks are you? _____

Did you have difficult conceiving? ☐ Yes ☐ No

If yes, please explain _____

Have you used any form of hormonal contraceptives ☐ Yes ☐ No

If yes, which ones and how long? _____

Have you experienced morning sickness? ☐ Yes ☐ No

If yes, please explain _____

What type of exercise are you currently performing? _____

PREGNANCY QUESTIONNAIRE

Please tell us about your current diet, and any dietary restrictions

_____

Have you taken any medications or supplements during your pregnancy ☐ Yes ☐ No

If yes, please explain _____

Have you had any slips, falls or other physical traumas during this pregnancy? ☐ Yes ☐ No

If yes, please explain _____

Have you had any major emotional stressors during this pregnancy? ☐ Yes ☐ No

If yes, please explain _____

What are your top 3 goals for this pregnancy?

_____

_____

_____

Do you currently have a birth plan? ☐ Yes ☐ No

If yes, please explain _____

Are you taking any pre-natal or birthing classes? ☐ Yes ☐ No

If yes, please explain _____

Who is your OBGYN, Group, and/or Midwife? _____

Will they be present for delivery? ☐ Yes ☐ No

Do you intend to have a birth coach or doula present? ☐ Yes ☐ No

If yes, please explain _____

Do you wish to have a natural and/or medicine-free labor and delivery? ☐ Yes ☐ No

Any concerns? _____

Do you plan on breastfeeding your child? ☐ Yes ☐ No

What would you like to gain from chiropractic care during your pregnancy?

_____

Is there anything else you'd like to tell us about your pregnancy or birth plan?

_____

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

Patient Name _____ Patient File # _____

The primary treatment used by Healing Hands Family Chiropractic is the spinal adjustment. We will use that procedure to treat you.

The nature of the Chiropractic adjustment.
We will use our hands or a mechanical device upon your body in such a way as to move your joints. That may cause an audible "pop" or "click", much as you have experienced when you "crack" your knuckles. You may feel or sense movement.

The material risks inherent in Chiropractic adjustment.
As with any health care procedure, there are certain complications, which may arise during a chiropractic adjustment. Those complications include: fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment.

The probability of those risks occurring.
Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during the examination and x-ray. Stroke has been the subject of tremendous disagreement within and without the professions and with one prominent authority saying that there is at most a one-in-a-million chance of such an outcome. Since even that risk should be avoided if possible, we employ tests in our examination, which are designed to identify if you may be susceptible to that kind of injury. The other complications are also generally described as "rare".

_____ _____

Patient Signature Date

_____

Printed Name

FINANCIAL POLICIES AND TERMS OF ACCEPTANCE OF CARE

It is important for each patient to understand both the objectives and methods of chiropractic care to prevent any confusion or problems in the future. Please take time to review the information below.

Adjustment: An adjustment is the specific application of forces and physiotherapy to facilitate the reduction or correction of spinal misalignment (subluxation).

Vertebral Subluxation: a misalignment of one or more of the 24 vertebrae in the spinal column which causes the alteration of both muscle and nerve function. This will interfere with the transmission of nerve impulses which can cause the lessening of the body's ability to function properly.

Our office does not diagnose or treat any diseases or conditions other than Vertebral Subluxation. However, if during the course of an examination we find a non-chiropractic or unusual finding, we will advise you. If you desire advice, diagnosis or treatment for those findings, we recommend you seek out the services of your primary care provider. Regardless of what the disease is called, we do not offer to treat it, nor do we offer advice regarding the treatment prescribed by others.

All visit charges are payable when services are rendered. Healing Hands Family Chiropractic requires a courtesy call of giving at least 24 hours notice in the event you cannot keep your scheduled appointment. If we do not receive notification of a cancellation of your scheduled appointment within the 24 hour notice, your appointment will be considered a NO SHOW. We reserve the right to charge the full amount of the missed appointment. It is also our policy that appointments remain punctual; you will be given 10 minute after the start of your scheduled appointment before you are considered a NO SHOW. Healing Hands Family Chiropractic also reserves the right to reschedule any appointments where the patient shows up after the 10 minute start of their appointment and you will be charged the full amount of the missed appointment.

We also offer multiple ways to pay including cash, check or credit card. Please be aware that if you choose to pay by credit or debit card, there will be an additional 3% convenience fee for all transactions.

I (please print)_____ have read and fully understand the above Policies and Terms of Acceptance, and hereby grant permission to receive chiropractic services.

Patient signature: _____
Date:_____

PRIVACY PRACTICES

Protected health information (PHI) will only be released from our practice with a properly executed authorization from the patient or his/her personal representative, except for treatment, payment or health care operations (TPO) and as otherwise required by law. Examples of some instances in which we are required to disclose your PHI include:

Public health actions; information regarding victims of abuse; neglect or domestic violence; health oversight activities; judicial and administrative proceedings; law enforcement purposes; organ donation purposes; research purposes under certain circumstances; national security and intelligence; correctional institutions; and Worker's Compensation.

Healing Hands Family Chiropractic will only use or disclose PHI at any time when requested but actions taken prior to revocation are excluded. If authorization is a condition of obtaining insurance coverage and the authorization is revoked, the insurer may contest a claim under the policy.

Authorizations must be properly executed by the patient or his/her personal representative. It should include: the date signed, specific PHI to be released or used, to whom this use or release relates, and an expiration date for the authorization.

I (print name)_____ acknowledge, understand and agree to the Privacy Practices of Healing Hands Family Chiropractic.

Patient Signature:_____Date:_____