New Patient Application - Pregnancy

Welcome to our Practice! Please thoroughly complete all questions. Thank you.

Name:_____ Today's Date:_____

Preferred Name: _____ Birthdate: ____/____/____ Age:_____

Address:_____ Email:_____

City/State/Zip:_____ Receive quarterly Newsletter: Yes / No

Phone: Home:_____ Work:_____ Cell:_____

Status: Married / Widow / Divorced / Single Social Security #: _____

Who may we thank for referring you? _____

Occupation: _____

Employers name: _____ Phone: _____

Spouse's name: _____ Phone:_____

Spouse's employer:_____ Phone:_____

Children's names & ages:_____

Emergency Contact: _____ Phone: _____ Other: _____

Favorite hobbies or interests: _____

Your Prior Doctor of Chiropractic: _____

City, State: _____ Approximate date of last Chiropractic treatment: _____

Chiropractic adjusting techniques you've had success with: _____

General Practitioner name: _____

Phone:_____ City, State: _____

Please rate 1 (poor) to 10 (excellent) the quality of healthcare you feel you receive from your GP:

_____

Other Specialists you are currently under care with:

Name: _____ Phone:_____

Name: _____ Phone:_____

Name: _____ Phone:_____

Method of payment for first visit

____ Cash ____ Check ____ Credit Card

Person Responsible for payment:

Name: _____

Phone Number:_____

Address: _____

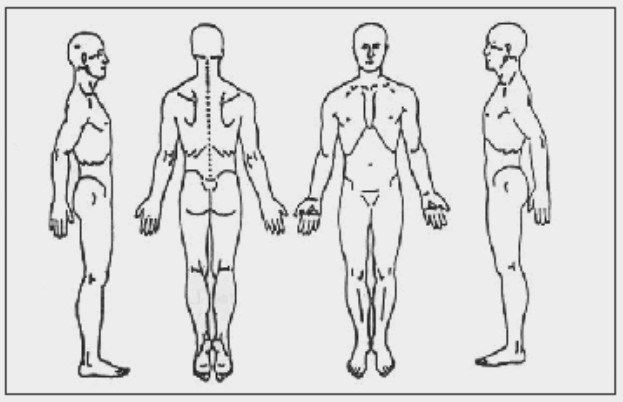
City:_____

State/Zip:_____

Do you have Health (crisis) Insurance? Y N

Insurance Company: _____

Mark Area(s) of Health Concerns:



Health reasons for consulting our office:

1._____ 2. _____

3._____ 4. _____

Have you had same or similar problem(s) before? ___Yes ___No

How long?_____ Please explain:_____

_____

Does this condition interfere with your: ____work _____sleep ___ daily routine_____
Father/Mother/Brother/Sister/Children, with similar problems?

_____

Is this the result of an auto or work injury? _____ If so, when? _____

If this is a work injury, is there a panel chiropractor that your company's Workmen's Compensation Insurances requires you to see in the first 90 Days? If so, who?_____

Other doctors who have treated this problem: _____

What treatments did you receive: _____

Medication(s) you currently take: _____

_____

Do you take supplements? Yes or No If yes, please list_____

Is there any chance you are pregnant? Yes____ No ____

What do you understand chiropractic care to be?_____

Do you know what a subluxation is? Yes or No If yes, please describe:

_____

Do you play any sports or exercise regularly? Yes or No If yes please describe_____

_____

Do you smoke? Yes or No If yes how many cigarettes/packs a day?_____

If any of the following have happened to you, give approximate dates & briefly describe injury:

Auto Accidents: _____ Motorcycle accidents: _____

Falls or other injuries: _____ Spinal or neck injuries: _____

Broken Bones: _____ Knocked unconscious: _____

Surgeries: _____ Health problems of parents: _____

Do you or have you had any of the following? Please write *C* of current and *P* for Past

___Angina ___Arthritis ___Asthma ___Allergies ___Carpal Tunnel ___Cancer ___Diabetes ___Emphysema ___Gout ___Heart Disease ___High Blood Pressure ___Kidney Disease ___Low Blood Pressure ___Migraines ___Numbness/tingling ___ Sciatica ___Seizures ___Sinus Problems ___Spinal curvature ___Stroke ___Thyroid disorder ___Tuberculosis ___Ulcers

The above information is true and accurate to the best of my knowledge. My reason for consultation with the Doctor is for evaluation of my physical health and the potential for improvement.

Patient or Guardian Signature: _____

Date: __/__/__

Pregnancy Specific History

Prenatal history:

1) Is this your first pregnancy? _____

2) How many other births have you had? _____

3) How many weeks pregnant are you now? _____ Due Date:_____

4) Have you experienced any traumas (accidents, falls) during this/past pregnancy? _____

Please describe: _____

6) Do you smoke or drink alcohol? _____

7) Have you had any evaluation procedures (ultrasound, amniocentesis, chorionic villus sampling)?

_____

8) Please list dates, frequency and reason for these procedures:

_____

9) How has your diet been during this pregnancy? _____

10) Have there been any stressful events in your life during this pregnancy? _____

_____

11) What are your most significant fears associated with this birth? _____

_____

12) Who is your birth care provider? _____

13) Will you have someone with you at birth for support (other than birth care provider)?

Please specify who: _____

14) Where do you plan on delivering? _____

15) Have you put together a birth plan? _____

Previous Birth History:

Please print this page for each previous delivery

1) Place of birth: Hospital, Birthing Center, Home.

2) Delivering Practitioner: OB/Gyn, Certified Nurse Midwife, Certified Practicing Midwife, Lay Midwife_____

3) Position of Delivery: Lithotomy position (on back with feet up), On Your Side, Kneeling, Squatting, Other? _____

4) Was labor induced? (Contractions were stimulated prior to the natural onset of labor) Yes No

f yes, specify type: Pitocin, Prostagland Gel (applied to your cervix), Unknown

5) Were your membranes ruptured by your care provider? Yes No Unknown

6) Were contractions stimulated intravenously with pitocin once labor started? Yes No

7) Did you receive any pain medications or anesthesia? Yes No Unknown Type_____

If you had an epidural, how many centimeters were you dilated when it was administered? _____

8) Did you experience back pain during labor? Yes No Unknown

9) Did you deliver vaginally? Yes No

10) Baby presentation at time of delivery: Normal, Posterior, Brow, Facial, Breech,

If breech, specify type: Footling, Frank, Complete, Kneeling

Was there any visible injury to your baby? Yes No Unknown

If so, where on your baby was the injury sustained?_____

11) Did your care provider assist delivery with his/her hands? Yes No Unknown

Was there any turning of the neck, or traction (pulling) applied to the neck? Yes No Unknown

12) Were operative devices used to facilitate the birth? Yes No Unknown

Which type? Forceps Vacuum Extraction

If yes, were there any visible signs of injury to your baby? Yes No Unknown

If yes, where was the injury sustained?_____

13) Was there a birthing coach present? Husband, Doula, Friend, Other

14) At what week of pregnancy was your baby born? _____

OLDE TOWNE FAMILY CHIROPRACTIC

Patient Authorization regarding chiropractic care provided in an "education driven" environment

It is the practice of this office to provide chiropractic care in an "education driven" environment. Education driven adjusting involves a learning environment for a community of patients being cared for in a common adjusting room. Patients are within sight and hearing range of one another thus profoundly deepening the competency of how your ability to learn can enhance your recovery. A private or confidential setting is always available and accessible should such a less recovery centered and more exam or history driven exchange be necessary.

We provide the ability to protect you from "incidental disclosures" of health information by reminding you that if you wish to speak on private matters we may request a separate though less educationally productive and beneficial setting. Research has proven that the leading cause of death in the world is poorly made decisions. For this reason, even though it is more demanding upon the doctors and staff, we uphold the disciplines to function in this educationally driven setting so you can hear and learn from more exchanges and examples of ideal health care. In many instances, it is evident that doctors need to educate people may quite possibly be more important than caring for them if we are truly dedicated to making sustainable advances in healthcare.

Please grow your deliberateness at keeping your ears and eyes open and engaged with what every doctor and patient is asking and responding to. These actions will help you get well faster, stay well longer, stop perpetuating previous habits which may have been counterproductive to true health care and more.

Your signature indicates your understanding of this more deliberate and advanced approach to your appointments.

_____

Name (Printed) Signature Date

Cancellation/No-Show Policy for Massage Therapy/Muscle Work

It is the policy of this office that if you find it necessary to cancel or change an appointment you must allow at least 24 hours prior notice. Missed and canceled appointments without proper notification will result in a $30.00 cancellation fee.

If you are late for an appointment, it is necessary to still end at the appointed hour, so not to affect the appointment following you.

_____

Signature Date