GENERAL INFORMATION

Name_____ Today's Date ____/____/____

Address_____

City/State/Zip _____

Mobile Phone # _____ Other Phone # _____

Your Birthdate _____

Occupation_____ Employer _____

Relationship: *Single* *Married* *Partner* *Widow* Children: *Yes* *No*

How did you find us? Who can we thank for referring you? _____

PREVIOUS BIRTH EXPERIENCE

Is this your first pregnancy? ___ Yes ___ No

If no, please tell us about your previous pregnancy and and/or birth experience(s)? (Complications, duration,

interventions, etc.) _____

_____

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

If no, what do you plan to change? _____

_____

CONCEPTION & EARLY PREGNANCY

What is your expected due date? _____

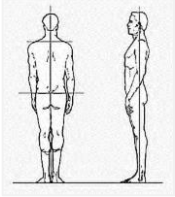
Did you have any difficulty conceiving? ___ Yes ___ No
If yes, please explain: _____

Have you used any form of hormonal or oral contraceptives? ___ Yes ___ No

If yes, which ones and for how long? _____

Have you experienced morning sickness? ___ Yes ___ No

(For office use only) Doctor Notes
Oc 1 2 3 4 5 6 7 1 2 3 4 5 6 7 8 9 10 11 12 1 2 3 4 5 S LIl RIl Ext _____ _____
ROM: Cer – F E RR LR RB LB Lum –F E RR LR RB LB



CURRENT HEALTH CONDITIONS

What type of exercise are you currently doing? _____

What is your current diet? Any dietary restrictions? _____

_____

How many hours do you sleep per day on average? Do you feel rested? _____

What do you do for play, relaxation, or fun? _____

What medications and/or supplements are you taking during this pregnancy? _____

_____

Have you had any falls or other physical trauma during your pregnancy? ___ Yes ___ No
If yes, please explain: _____

Have you had any major emotional stressors during your pregnancy? ___ Yes ___ No
If yes, please explain: _____

YOUR BIRTH PLAN

Do you have a current birth plan? ___ Yes ___ No

What are your top three goals for this pregnancy?

1._____

2._____

3._____

Are you taking any pre-natal birthing classes? ___ Yes (list any) _____ ___ No

Who is your OB/GYN or Midwife? _____

Where are you planning to give birth? _____

Do you plan to have a doula present during labor and delivery? ___ Yes ___ No

Do you have any concerns about your labor and delivery? _____

_____

POST– NATAL PLAN

Do you plan on breastfeeding? ___ Yes ___ No

What is your vaccination plan? ___ Regular schedule ___ Delayed Schedule ___ No Vaccinations

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

_____

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

_____

What questions do you have for us today? _____

_____

REVIEW OF SYSTEMS

CARDIOVASCULAR

Present	Past	
☐	☐	Blood Pressure
☐	☐	Aortic Aneurysm
☐	☐	Heart Disease
☐	☐	Cholesterol
☐	☐	Stroke

ALLERGIC/IMMUNOLOGICAL

Present	Past	
☐	☐	Autoimmune Disorder
☐	☐	Chronic Allergies
☐	☐	Seasonal Allergies
☐	☐	Food Allergies
☐	☐	HIV/AIDS

ENDOCRINE

Present	Past	
☐	☐	Hyperthyroid Issues
☐	☐	Hypothyroid Issues
☐	☐	Type 1 Diabetes
☐	☐	Type 2 Diabetes
☐	☐	Menstrual Problems
☐	☐	Polycystic Ovarian Synd.

NEUROLOGICAL

Present	Past	
☐	☐	Numbness/Tingling
☐	☐	Pinched Nerves
☐	☐	Radiating Pain
☐	☐	Sciatica
☐	☐	Balance/Coordination
☐	☐	Autism/Spectrum Dis.
☐	☐	Migraine Headaches
☐	☐	ADHD/ADD/Sensory Processing Disorder

CONSTITUTIONAL

Present	Past	
☐	☐	Weight Loss/Gain
☐	☐	Energy Level Low
☐	☐	Energy Level High
☐	☐	Difficulty Sleeping
☐	☐	Chronic Fatigue
☐	☐	RLS
☐	☐	Pregnancy/Fertility
☐	☐	Obesity

MUSCULOSKELETAL

Present	Past	
☐	☐	Poor Posture
☐	☐	Neck Pain
☐	☐	Back Pain
☐	☐	Arthritis
☐	☐	Rheumatoid Arthritis
☐	☐	Joint Stiffness
☐	☐	Osteoporosis
☐	☐	Broken Bones
☐	☐	Gout

GASTROINTESTINAL

Present	Past	
☐	☐	Acid Reflux
☐	☐	Bowel Problems
☐	☐	Ulcers
☐	☐	Gallbladder Problems
☐	☐	Liver Problems
☐	☐	Diarrhea
☐	☐	Nausea/Vomiting
☐	☐	Chrohn's Disease

PSYCHIATRIC

Present	Past	
☐	☐	Depression
☐	☐	Anxiety Disorder
☐	☐	OCD
☐	☐	Bipolar Disorder
☐	☐	Seasonal Affective Dis.

RESPIRATORY

Present	Past	
☐	☐	Asthma
☐	☐	COPD

EAR/NOSE/THROAT

Present	Past	
☐	☐	Ear Infections
☐	☐	Dizziness
☐	☐	Sinus Congestion
☐	☐	Hearing Loss

GENITOURINARY

Present	Past	
☐	☐	Kidney Disease
☐	☐	Prostate Problems

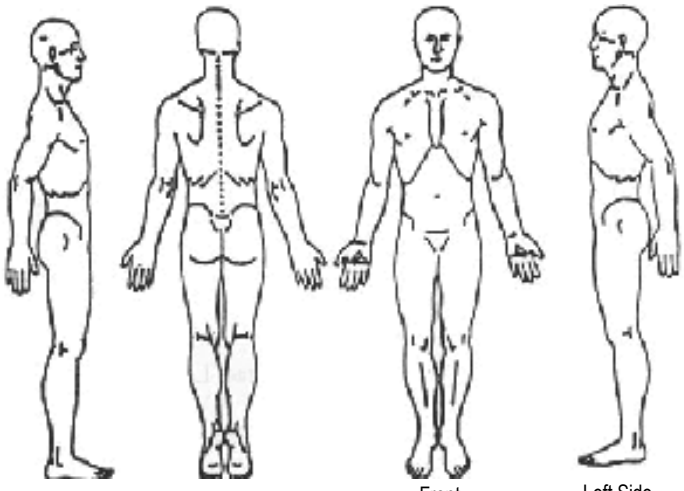
Other conditions or previous surgeries: _____

HEALTH EVALUATION & PAIN DIAGRAM

The following seven categories help shape your health and life satisfaction. Please indicate your current satisfaction in each category with an (X) on the lines below.

	LOW ..... HIGH
PHYSICAL	.....
MENTAL	.....
SPIRITUAL	.....
FAMILIAL	.....
SOCIAL	.....
FINANCIAL	.....
VOCATIONAL	.....

Mark on diagram below where you may have pain or other symptoms.



Right Side Back Front Left Side

Signed _____ Date_____/_____/_____

Voicemail Preferences

____ I agree that voice messages can be left on any of the phone numbers listed on first page of this form with details about my appointments and chiropractic care.

Email Preferences

Email Address: _____

____ I agree to receive personal emails regarding my care, appointments, and payments.

____ I would like to receive, or continue receiving, monthly email newsletters with health tips, research, recipes and information about Thrive Chiropractic events. I can easily unsubscribe at any time if I do not find these newsletters valuable.

Text Message Reminders

____ I would like to receive, or continue receiving, text message reminders 24 hours in advance of my scheduled appointments.

Cancellation Policy

____ I understand that Thrive Chiropractic requires 24-hour notice for canceling appointments. I may be charged $45 for any missed appointments if I fail to show up or fail to give 24-hour notice.

Signature: _____ Date: _____

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as “informed consent” and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but

not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains.

With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery.

Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____

Signature: _____

Date: _____

Parent / Guardian: _____

Signature: _____

Date: _____

Witness Name: _____

Signature: _____

Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Date: _____

You may refuse to sign this acknowledgement. In refusing, we *may not be allowed* to process your insurance claims.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

_____ _____

Print Patient Name **Signature** of Patient or Guardian

_____ _____

Legal Representative / Guardian Relationship to Patient

_____

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment _____

I could not communicate with the patient _____

The patient refused to sign _____

The patient was unable to sign because _____

Other (please describe) _____

Signature of Privacy Officer: _____