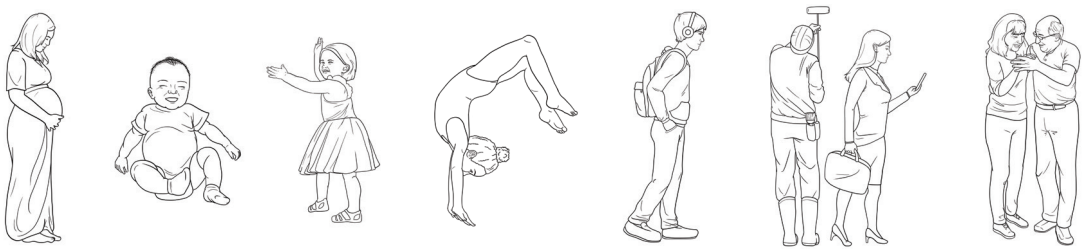


thrive CHIROPRACTIC
ADJUST. ADVANCE. THRIVE.

# Pregnancy Form

## General Information

Name _____ Today's Date _____

Address _____

City/State/Zip _____

Mobile Phone # _____ Other Phone # _____

Occupation _____ Employer _____

Your Birthdate _____ Relationship: ◯ *Single* ◯ *Married* ◯ *Partner* ◯ *Widow*

Do you have kids? ◯ *Yes* ◯ *No* Age(s) _____

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/or birth experience(s)? (*Complications*, *duration*, *interventions*, *etc.*) _____

_____

Would you like to change anything this pregnancy? _____

_____

## Conception and 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? _____

## Current Health Status

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? _____

Are you taking any medications and/or supplements 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

What are your top three goals for this pregnancy and birth?

1. _____

2. _____

3. _____

Are you taking any pre-natal birthing classes? _____

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*

## Your Goals

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

_____

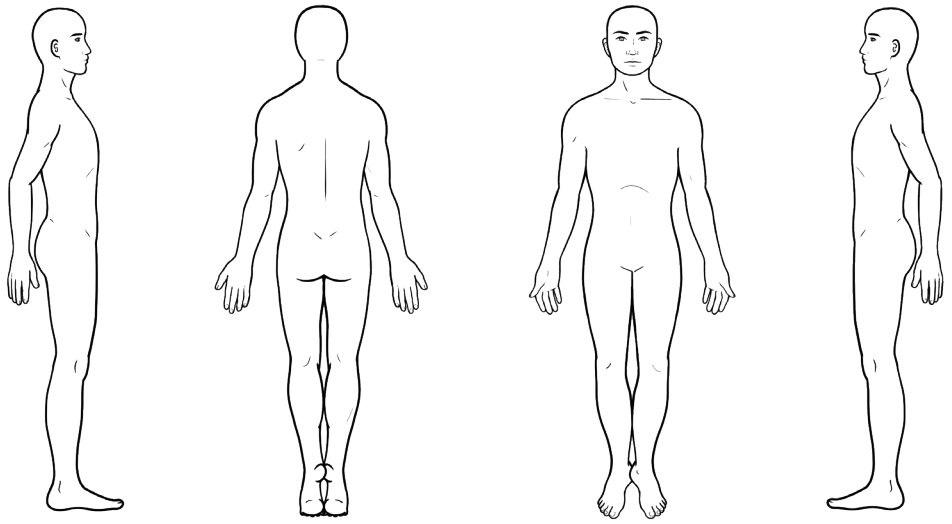
What would you like to gain from chiropractic care during your pregnancy? _____

_____

What questions do you have for us today? _____

# Pain and Symptom Diagram

Use the Adobe Acrobat Highlight Text tool to highlight areas on the diagram where you may have pain or symptoms, or describe below:



Right Side | Back | Front | Left Side

# Review of Body Systems

Check the appropriate boxes for anything you are presently experiencing, and/or have experienced in the past. Leave the boxes blank if you have never experienced the condition.

### Musculoskeletal

| Present | Past | |
|---|---|---|
| ☐ | ☐ | Poor Posture |
| ☐ | ☐ | Neck Pain |
| ☐ | ☐ | Back Pain |
| ☐ | ☐ | Arthritis |
| ☐ | ☐ | Rheumatoid Arthritis |
| ☐ | ☐ | Joint Stiffness |

### Gastrointestinal

| Present | Past | |
|---|---|---|
| ☐ | ☐ | Acid Reflux |
| ☐ | ☐ | Constipation |
| ☐ | ☐ | Ulcers |
| ☐ | ☐ | Gallbladder Issues |
| ☐ | ☐ | Liver Issues |
| ☐ | ☐ | Diarrhea |
| ☐ | ☐ | IBS |

### Ear/Nose/Throat

| Present | Past | |
|---|---|---|
| ☐ | ☐ | Ear Infections |
| ☐ | ☐ | Dizziness |
| ☐ | ☐ | Sinus Congestion |

### Respiratory

| Present | Past | |
|---|---|---|
| ☐ | ☐ | Asthma |
| ☐ | ☐ | COPD |

### Neurological

| Present | Past | |
|---|---|---|
| ☐ | ☐ | Tension Headaches |
| ☐ | ☐ | Numbness/Tingling |
| ☐ | ☐ | Pinched Nerves |
| ☐ | ☐ | Radiating Pain |
| ☐ | ☐ | Sciatica |
| ☐ | ☐ | Balance/Coordination |
| ☐ | ☐ | Migraine Headaches |
| ☐ | ☐ | ADHD/ADD |
| ☐ | ☐ | Sensory Processing |

### Constitutional

| Present | Past | |
|---|---|---|
| ☐ | ☐ | Weight Loss/Gain |
| ☐ | ☐ | Low Energy Level |
| ☐ | ☐ | Difficulty Sleeping |

### Psychiatric

| Present | Past | |
|---|---|---|
| ☐ | ☐ | Depression |
| ☐ | ☐ | Anxiety |
| ☐ | ☐ | OCD |
| ☐ | ☐ | Bipolar |

### Genitourinary

| Present | Past | |
|---|---|---|
| ☐ | ☐ | Kidney Disease |
| ☐ | ☐ | Prostate Issues |

### Endocrine

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

### Cardiovascular

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

### Allergic/Immunological

| Present | Past | |
|---|---|---|
| ☐ | ☐ | Autoimmune Disorder |
| ☐ | ☐ | Seasonal Allergies |
| ☐ | ☐ | Food Allergies |
| ☐ | ☐ | HIV/AIDS |

### Pathology

| Present | Past | |
|---|---|---|
| ☐ | ☐ | Cancer |

_____

## 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.

## Cancelation 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: _____

## Acknowledgment of Receipt of Notice of Privacy Practices

Date: _____

You may refuse to sign this acknowledgment. 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

# 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: _____