ACTIVELIVING CHIROPRACTIC®
SPINE + SPORTS INJURY

453 W. Main Street. Mt. Orab, Ohio 45154

937.444.6000 activelivingichiropractic.org

Pregnant Patient Introduction Form

Date: _____

INTRODUCTION

Patient name: _____ Estimated Due Date: _____

Address: _____ Home Phone: _____ ☐

City, State, Zip: _____ Work Phone: _____ ☐

Email address: _____ Cell Phone: _____ ☐

Birth date: _____ Age_____ Marital Status: _____ Check preferred method of contact

Occupation: _____ Employer: _____ Employer Address: _____

Spouse/Partner: _____ Birth date: _____ Spouse Occupation: _____

Spouse Employer: _____ Employer Address: _____

Who is responsible for your bill? Self ☐ Spouse ☐ Other ☐ Insurance Company: _____ Policy #_____

Emergency Contact: _____ Phone: _____

Who can we thank for referring you to our office?:_____

Previous Chiropractic Care: ☐ Yes ☐ No Date: _____ Doctor: _____

Were X-rays taken: ☐ Yes ☐ No Date: _____

MEDICAL HISTORY

Please list any/all medications you are taking at this time and precise dosage per day in mg. Please include prescription drugs, over the counter medications, and any vitamins and supplements.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Please attach additional sheet if necessary.

Do you have any known medication allergies? ☐ Yes ☐ No

Please list and explain reaction: _____

_____

_____

Pregnant Patient Pain Index

PAIN INDICATOR

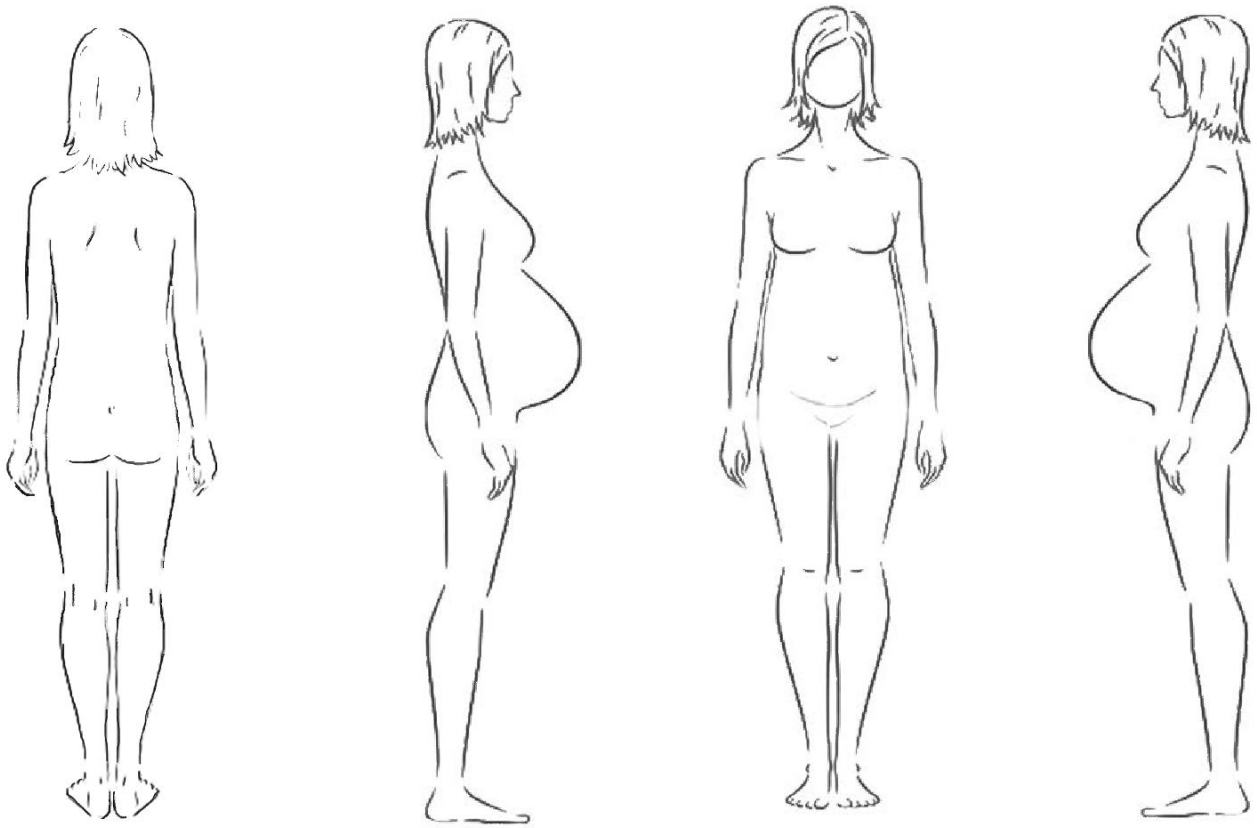
Are you currently experiencing any pain or discomfort? ☐ Yes ☐ No

If yes, please answer the following questions:

How long have you had pain? _____ Years _____ Months _____ Weeks

If you are not experiencing pain, but intend to begin chiropractic care as a proactive approach to optimal health and wellness throughout your pregnancy – please go on to page 3.

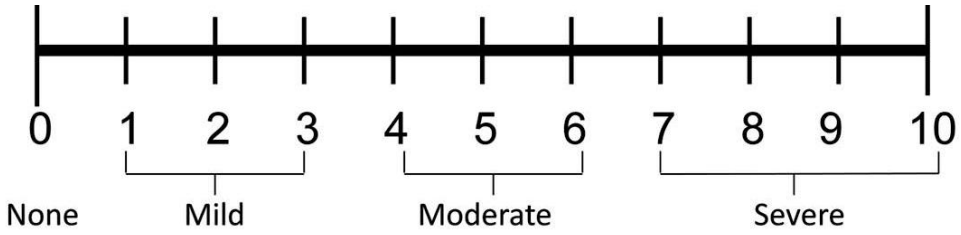
On the diagram below, please indicate where you are experiencing pain or other symptoms:



A = Ache **B = Burning** **N = Numbness** **P = Pins & Needles** **S = Stabbing** **O = Other**

PAIN SCALE

On a scale from 0 to 10 please indicate the severity of your pain: _____



In your own words, please explain what your biggest health concern is: _____

_____

Pregnancy Questionnaire

PREVIOUS BIRTH EXPERIENCE

Please circle the correct response. Sign and date when completed.

Is this your first pregnancy? ☐ Yes ☐ No

If no, please tell us about your previous pregnancy and/or birth experience(s) i.e., duration, interventions, etc. _____

_____

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

If no, what would you like to change? _____

CONCEPTION & PREGNANCY

When is your expected or calculated due date? _____

Did you have any difficulty conceiving? ☐ Yes ☐ No

If yes, please explain: _____

_____

When was your last menstrual cycle? _____

What was your pre-pregnancy weight? _____

Current weight? _____

CURRENT HEALTH CONDITIONS

What type of exercise(s) are you currently performing? _____

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 major emotional stressors during your pregnancy? ☐ Yes ☐ No

If yes, please explain: _____

_____

BIRTH PLAN

What are your top 3 goals for this pregnancy?

1. _____
2. _____
3. _____

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 OB/GYN or Midwife? _____ Will they be present for the delivery? ☐ Yes ☐ No

BIRTH PLAN CONTINNUED

Who is your birth provider? _____ Do you plan to have a doula or birth coach present? ☐ Yes ☐ No If yes, please explain:

_____

_____

Do you wish to have a natural vaginal labor and delivery? ☐ Yes ☐ No

If not, what concerns do you have? _____

_____

YOUR POST-BRITH PLAN

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

Is there anything else you'd like to tell us about your pregnancy or birth plan? ☐ Yes ☐ No

If yes, please explain: _____

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

_____

Are there any burning questions you want to be sure to ask today? ☐ Yes ☐ No

If yes, please explain: _____

_____

_____

Consent for Purposes of Treatment/Payment & Healthcare Operations

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign at clinic's request, and convey directly to **Active Living Chiropractic** all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby authorize the doctor to release any and all medical information to other healthcare providers involved in my care including but not limited to my primary care physician. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

_____ _____

Signature of Insured/Guardian Date

Terms of Acceptance

The goal of our office is to enable patients to gain control of their health. To attain this we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you.

Please read the below and if you have any questions please feel free to ask one of our staff members.

Informed Consent:

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at Active Living Chiropractic, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Communications:

In the event that we would need to communicate your healthcare information, to whom may we do so?

Spouse: _____

Children: _____

Others: _____

No one: ____

May we leave messages regarding your personal healthcare information on any answering device,

i.e. home answering machines or voicemails? Yes ( ) No ( )

Acknowledgement

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Print Name: _____

Signature: _____ Date: _____