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Pregnancy Health Story Form

Personal Information

Name _____ Age _____ Date of Birth _____

Home Address _____City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Cell Phone Provider _____ Email Address _____

If Under 18 yoa, Guardian(s) Name(s) _____

Occupation _____Name of Employer _____

Marital Status: ❑S ❑M ❑D ❑W ❑O Spouse's Name _____ Age _____

Emergency Contact _____ Emergency Relation _____ Emergency Phone _____

Hobbies _____

Whom may we thank for referring you to our office?_____

How old is/was your oldest grandparent that has ever lived? _____

Health Care Practitioner History

Have you ever received chiropractic care? ❑ Yes ❑ No Name of D.C._____

Reason _____ How long? _____ Date of last visit _____

Why was care stopped? _____

Were you pleased with care? ❑ Yes ❑ No Please explain _____

_____

Reason for Seeking Chiropractic Care

What concerns do you feel Pure Light Family Chiropractic can address for you? _____

_____

If these concerns went away, how would it change your life? _____

_____

When did this condition first begin? _____

How did the condition start? ❑ Suddenly ❑ Gradually ❑ Post-Injury

Is this condition ❑ Getting Worse ❑ Improving ❑ Intermittent ❑ Constant ❑ Unsure

What makes the condition better? _____

What makes the condition worse? _____

Have you ever had a similar condition? ❑ Yes ❑ No

Please explain _____

Have you received care for this condition before? ❑ Yes ❑ No

Please explain _____

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Pregnancy History

Calculated Due Date _____ How many weeks gestation is your baby? _____

Date of last menstrual cycle _____ Do you currently have a birth plan? ❑ Yes ❑ No

Intended Delivery ❑ Home ❑ Birth Center ❑ Hospital ❑ Other _____

My ❑ Obstetrician ❑ Midwife ❑ Family Physician is _____

Do you have a doula? ❑ Yes ❑ No If yes, who? _____

Do you exercise regularly? ❑ Yes ❑ No If yes, how often? _____

The reason for this visit is a result of …

❑ Pregnancy Wellness ❑ Breech Presentation ❑ Backache ❑ Headache ❑ Trauma

❑ Other_____

Please list your number of Pregnancies _____ Vaginal Deliveries _____ Cesarean Surgery _____ Miscarriages _____

Do you plan to follow the same plan as your previous birth(s)? ❑ Yes ❑ No

If no, what would you like to change _____

_____

Infertility issues ❑ Yes ❑ No If yes, please explain _____

_____

Please explain any other complications with this or previous pregnancies _____

_____

Have you ever experienced…

Dizziness	❑ Before Pregnancy	❑ During Pregnancy	❑ Postpartum
Backaches	❑ Before Pregnancy	❑ During Pregnancy	❑ Postpartum
Water Retention	❑ Before Pregnancy	❑ During Pregnancy	❑ Postpartum
Diabetes	❑ Before Pregnancy	❑ During Pregnancy	❑ Postpartum
High Blood Pressure	❑ Before Pregnancy	❑ During Pregnancy	❑ Postpartum
Headaches	❑ Before Pregnancy	❑ During Pregnancy	❑ Postpartum
Asthma	❑ Before Pregnancy	❑ During Pregnancy	❑ Postpartum
Stomach Trouble	❑ Before Pregnancy	❑ During Pregnancy	❑ Postpartum
Sinus Trouble	❑ Before Pregnancy	❑ During Pregnancy	❑ Postpartum
Neck Pain	❑ Before Pregnancy	❑ During Pregnancy	❑ Postpartum

Once you give birth, do you plan to breastfeed? ❑ Yes ❑ No

What do you intend to do for vaccinations? _____

_____

Your Top 3 Health Goals

Please tell us your top 3 health goals for this pregnancy:

1. _____
2. _____
3. _____

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Physical Stress

Please list the major traumas, hospitalizations, or surgeries from your childhood up to the present.

_____

_____

_____

Have you ever been involved in a car accident? ❑ Yes ❑ No If yes, please explain _____

_____

Have you ever been involved in any high impact or contact-type sports (i.e. soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)? ❑ Yes ❑ No If yes, please explain _____

_____

How do you sleep? ❑ Back ❑ Side ❑ Stomach Do you wake up: ❑ Refreshed ❑ Tired & Groggy

List any problems with flexibility _____

How many hours per day to you typically spend sitting at a desk or on a computer, tablet, or phone? _____

Chemical Stress

Do you <u>presently</u> consume any of the following?

❑ Caffeine	❑ Alcohol	❑ Tobacco	❑ Over-the-counter drugs	❑ Prescribed drugs
❑ Sugar	❑ Dairy	❑ Gluten	❑ Processed Foods	❑ Artificial Sweetener

Please list any present prescription or over-the-counter drugs that you are taking _____

_____

_____

Emotional Stress

Using the scale below, grade each of the following situations in your life.

0 – no stress **1** – a little stress **2** – moderate stress **3** – a lot of stress **4** – extreme stress

Regarding my life in general	0	1	2	3	4	Regarding my work and career	0	1	2	3	4
Regarding my relationships	0	1	2	3	4	Regarding my health and well-being	0	1	2	3	4
Regarding my finances	0	1	2	3	4	Regarding my time management skills	0	1	2	3	4

Please explain, in your own words, any areas in your life that you feel are causing you significant emotional stress:

_____

_____

Expectations of Care

I would like to experience the following benefits from chiropractic care:
Check all that apply

- ❑ Symptomatic relief of a problem
- ❑ Correction of the cause of a problem as well as relief
- ❑ Prevention of future problems
- ❑ Healthier spine and nerve system
- ❑ Optimal health on all levels
- ❑ Other_____

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Terms of Acceptance

When a person seeks chiropractic health care and we accept a person for such care, it is essential for both parties to be working towards the same objective.

Chiropractic has only one goal. It is important that each person understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of your chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our only practice objective is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.

(print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

Signature _____Date: _____

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Office Fee Schedule and Financial Policy

Service	Fees
Initial Discovery – First Visit	$90.00
Progress Discovery – Re-Evaluation	$45.00
Adjustment	$45.00
Birth Adjustment (Home birth or Birth Center)	$90.00

Financial Policy

We are committed to providing you with the best chiropractic care possible in a caring environment and have established our financial policies to achieve that goal. You will be expected to pay for your chiropractic care at the time the service is rendered unless you arrange and agree to a recommended care plan payment schedule in advance. These plans are designed to be the most cost effective way to keep you and your family as healthy as possible. They include your Crisis Care, Critical Transition and Lifestyle Care options. Details of these plans will be discussed with you during your Empowerment Session Report of Findings. Please choose one of the following documentation options:

- ❑ **Insurance – Superbill:** If you have insurance that covers out-of-network chiropractic care, we will give you all of the information you need to get reimbursed. This includes your diagnosis codes and details of charges on a specialized receipt called a superbill. We have found it is easier for your record keeping, and ours, if we give you receipts at the end of your second visit and then once per month after that. Just send your superbill to your insurance company, and they will communicate with you about your reimbursement. Remember, your agreement with your insurance company is between you and them.

- ❑ **No Insurance:** If you do not have health insurance, choose not to use your health insurance or are participating in Lifestyle Care, you may request a receipt for tax purposes or a Health Savings Account (HSA) indicating the total amount you have paid for chiropractic care during the year. There is no insurance documentation given with these receipts.

I have read and understand the above policy. I have indicated the option that applies to me.

Signature _____Date: _____

Consent to Care

I do hereby authorize the doctor(s) of Pure Light Family Chiropractic to administer chiropractic care that is necessary for my particular case. This may include consultation, examination, adjustments or any other procedure which is advisable and necessary for my health care.

I further understand that a fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not.

I understand that payment for care is out-of-pocket and paid before or directly after services are rendered. If I wish to obtain reimbursement from my health insurance company, Pure Light Family Chiropractic will supply the proper documentation necessary to receive reimbursement for services. Pure Light Family Chiropractic is not liable for any lack of reimbursement from my health insurance company.

I have read, understand and hereby request chiropractic care based on the terms of acceptance and the consent to care.

Your Name: (Printed) _____

Signature _____Date: _____

Health Care Authorization Form

I have been provided with a copy of the Notice of Privacy Practices for Protected Health Information. The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information (PHI) that will occur in my treatment, payment of my bills or in the performance of health care operations of this chiropractic office. A copy of our notice is attached and we encourage you to read it and request a copy if you would like one.

This Notice of Privacy Practice also describes my rights and duties of the chiropractor with respect to my Protected Health Information. I hereby give permission to Pure Light Family Chiropractic (PLFC) to use and/or disclose Protected Health Information in accordance with the following.

Specific Authorizations

- I give permission to PLFC to use my address, phone number and clinical records to contact me with appointment reminders, missed appointments notification, birthday cards, holiday related cards, newsletters, information about treatment alternatives or other health related information.
- If PLFC contacts me by phone, I give them the permissions to leave a phone message on my answering machine or voice mail.
- I give permission to PLFC to use my first name on a welcome board, referral board and birthday board, and social media (Facebook, Instagram etc).
- I give permission to PLFC to use my photograph on the patient picture bulletin board and other marketing materials such as their brochure, website, ads in print media, and social media (Facebook, Instagram etc).
- I give permission to PLFC to use any testimonial written by me for marketing purposes such as, sharing with other patients or potential patients, in their brochure, on their website, ads in print media, and social media (Facebook, Instagram etc).
- I give PLFC permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, the doctor will provide a room for these conversations.
- By signing this form you are giving PLFC permission to use and disclose your protected health information in accordance with the directives listed above.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance you access to quality health care and health information. This authorization will remain in effect for the duration of my care at PLFC plus 7 years or until revoked by me.

Right to Revoke Authorization

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action to reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of PLFC. The written notice must contain the following information:

Your name, Social Security number & date of birth;
A clear statement of you intent to revoke this AUTHORIZATION;
The date of your request; and
Your signature

The revocation is not effective until it is received by the Privacy Official.

This AUTHORIZATION is requested by PLFC for its own use/disclosure of PHI. (Minimum necessary standards apply)

I have the right to refuse to sign this AUTHORIZATION. If I refuse to sign this AUTHORIZATION, PLFC will not refuse to provide treatment however, it will not be possible for PLFC to file third party billing on my behalf and I will be responsible for 1) payment in full at the time services are provided to me 2) scheduling my own appointments since PLFC will be unable to contact me 3) all contact with PLFC regarding my care. *Additionally, any collection activity as permitted by law is not waived by refusal to sign the authorization.*

I have the right to inspect or cop, within boundaries, the protected health information to be used/disclosed. A reasonable fee for copying will apply. A copy of the signed authorization will be provided to me.

Health Care Authorization

I have read and understand this Healthcare Authorization Form and acknowledge receipt of The Notice of Privacy Practices for Protected Health Information. My signature below represents agreement with these practices.

My Name or Parent's Name (please print): _____
My Signature: _____
Today's date: _____

Name of Personal Representative (if someone is designated to act on your behalf)
Name (please print): _____
Signature of Personal Representative: _____
Description of Representative's Authority to Act on Patients Behalf: _____