pre-natal HEALTH RECORD

ABOUT YOU

NAME:	
ADDRESS:	
CITY:	**STATE/ZIP CODE:**
HOME PHONE:	**CELL PHONE:**
EMAIL ADDRESS:	

DATE OF BIRTH:	**AGE:**	**MARITAL STATUS:**
CHILDREN:		
HOW DID YOU HEAR ABOUT US?		

PREVIOUS PREGNANCY HISTORY

 # OF PREGNANCIES? **# OF BIRTHS?**

NAME & BIRTHDAYS OF CHILDREN:

PLEASE CHECK ANY OF THE FOLLOWING THAT WERE PREVIOUSLY USED:

- ❑ EPIDURAL
- ❑ PITOCIN
- ❑ FORCEPS
- ❑ VACUUM
- ❑ VAGINAL BIRTH
- ❑ C-SECTION
- ❑ BREECH PRESENTATION
- ❑ OTHER:

LENGTH OF ACTIVE LABOR(S):

DID YOU EXPERIENCE ANY OF THE FOLLOWING:

- ❑ GESTATIONAL DIABETES
- ❑ PRE-ECLAMPSIA
- ❑ ANEMIA
- ❑ OTHER:

DID YOU UTILIZE ANY NATURAL THERAPIES? If so, what?

CURRENT PREGNANCY

DUE DATE: **HOW MANY WEEKS ARE YOU?**

PLEASE CHECK IF THE PRACTITIONER IS PARTICIPIATING IN YOUR PRE-NATAL CARE AND PROVIDE THEIR NAME AND PHONE NUMBER

- ❑ OB/GYN _____
- ❑ MIDWIFE _____
- ❑ DOULA _____
- ❑ CHIROPRACTOR _____
- ❑ CRANIOSACRAL _____
- ❑ MASSAGE THERAPIST _____
- ❑ NUTRITION/HEALTH COUNSELOR _____

DO YOU PLAN TO VACCINATE?	**WOULD YOU LIKE MORE INFO ON VACCINATIONS?**

WHAT IS YOUR BIGGEST STRESSOR(S) ABOUT YOUR PREGNANCY?

EXERCISE & SLEEP HABITS

INSTRUCTIONS: *Please check all that apply to your normal lifestyle routine.*

❑ FLEXIBILITY / STRETCHING	What Kind?	How often?
❑ STRENGTH TRAINING	What Kind?	How often?
❑ CARDIO EXERCISE	What Kind?	How often?
❑ SIT FOR MORE THAN 8 HRS A DAY		
HOURS OF UNINTERRUPTED SLEEP/NIGHT		

YOUR INTERESTS...

INSTRUCTIONS: *Please check all items that you may be interested in.*

❑ HOME BIRTH	❑ MIDWIFE | DOULA	❑ BRADLEY BIRTH CLASSES	❑ PRE-NATAL YOGA	❑ REIKI | ENERGY MEDICINE
❑ WATER BIRTH	❑ CHIROPRACTIC	❑ MASSAGE THERAPY	❑ VITAMINS | SUPPLEMENTS	❑ NUTRITIONAL COUNSELING
❑ VACCINATION	❑ CRANIOSACRAL	❑ HOLISTIC PEDIATRICIANS	❑ HEALTHY LIVING CLASSES	❑ HEALTHY COOKING CLASSES

medical history

MEDICATIONS

INSTRUCTIONS: *Please list all medications (current and previous) and as much information as possible. This includes over-the-counter an prescription. If more room is needed, please include on additional piece of paper.*

MEDICATION	Dosage	Duration	Reason
Example: *Albuterol*	*1 puff as needed*	*1990 to Present*	*Asthma*

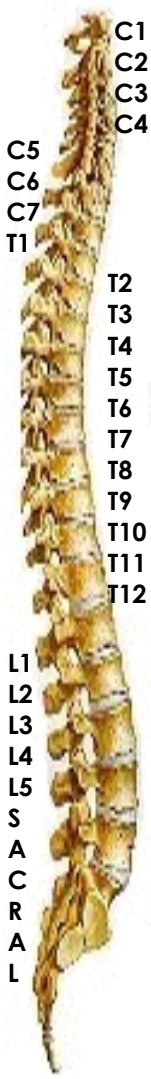
APPROXIMATE MONTHLY out-of-pocket COST:

OFFICE USE ONLY

YOUR CONCERNS

INSTRUCTIONS: *Please* ***circle*** *the health concerns or conditions you are* ***CURRENTLY*** *experiencing. Each area of concern relates to proper nerve function.*

Sore Throat
Thyroid Dysfunction
Stiff Neck
Radiating Arm Pain
Hand/Finger Numbness
Asthma
High Blood Pressure
Heart Conditions
Cholesterol Issues



Headaches
Migraines
Seizures / Epilepsy
Dizziness / Vision Issues
Allergies / Sinus Problems
Immune Dysfunction
Ear Aches/Infections
Fatigue
Head Colds
Attention / Focus Issues
Hearing Problems

Middle Back Pain
Congestion
Difficulty Breathing
Bronchitis | Pneumonia
Nausea
Gallbladder Conditions
Stomach Problems
Ulcers | Gastritis
Gas | Reflux
Kidney Stones

Constipation
Colitis
Diarrhea
Gas Pain
Irritable Bowel
Bladder Problems
Bowel Issues
Hemorrhoids
Vaginal Discharge
Vaginal Bleeding
Low Back Pain
Pain or Numbness in legs
Reproductive Problems

OTHER:

_____
_____
_____
_____
_____
_____
_____
_____

PREVIOUS MEDICAL CONDITIONS

INSTRUCTIONS: *Please list every condition or disease that you now have* ***or have had in the past****, (approximate) age you were diagnosed or it was discovered, how long you were treated or troubled by condition, any and all symptoms and treatments. Please use additional paper if needed.*

CONDITION	Age	Duration	Your Symptoms	Treatment Received
Example: *Kidney Stones*	*44 & 50*	*1 week & 3 months*	*Severe pain, vomiting, fever, blood in urine*	*Blood test, X-rays, Surgery*

lifestyle history

NUTRITIONAL OVERVIEW

INSTRUCTIONS: *Please check all that apply to your normal lifestyle routine. In the blank space, describe how often and/or how much is consumed.*

❑ HOME-COOKED MEALS	❑ FAST FOOD
❑ NON-ORGANIC MEAT	❑ LUNCH MEATS
❑ FISH	❑ TYPE OF BUTTER
❑ MOST COMMONLY USED MILK PRODUCT	
❑ MOST COMMONLY USED SWEETENER	
❑ FRUITS	❑ VEGGIES
❑ FILTERED WATER	❑ TAP or BOTTLED WATER
❑ CARBONATED BEVERAGES	❑ FRUIT JUICES
❑ TEAS	❑ COFFEE
❑ ALCOHOL	❑ TOBACCO USE
❑ CANDY	❑ GUM
HOW MANY MEALS DO YOU EAT A DAY (ON AVERAGE)?	
DO YOU DRINK LIQUIDS WITH MEALS?	
HOW MUCH WATER DO YOU DRINK DAILY?	
DO YOU EAT BREAKFAST?	
HOW OFTEN DO YOU HAVE A BOWEL MOVEMENT?	
DATE OF MOST RECENT BLOOD WORK	

SUPPLEMENTATION

INSTRUCTIONS: *Please list all supplements taken in the past 6 months. If more room is needed, please include on additional piece of paper.*

SUPPLEMENT	BRAND	Dosage	Duration	Reason
Example: *Vitamin D3*	*Metagenics*	*5000 iu*	*3 months*	*Immunity*

APPROXIMATE MONTHLY out-of-pocket COST:

TERMS OF ACCEPTANCE

When a patient seeks holistic care and we accept such a patient for care, it is essential for both to be working towards the same objective. Our office has only one goal. It is only when the patient understands both the objective and the method that they will be able to attain it. This will prevent any confusion or disappointment. I will alert the doctor and/or a staff member if I do not understand or accept part of treatment.

I hereby authorize the Doctor to work with my condition through the use of chiropractic adjustments, nutritional supplements and/or therapies, as he or she deems appropriate. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I understand and agree that health and insurance policies are an arrangement between an insurance carrier and myself. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will become immediately due and payable.

I understand that the Webster technique is a specific chiropractic analysis and adjustment. The goal of the adjustment is to reduce the effects of sacral subluxation and/or SI joint dysfunction, thus improving neuro-biomechanical function in the pelvis.

SIGNATURE:	DATE:

NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- *Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.*
- *Obtain payment from third party payers.*
- *Conduct normal healthcare operations such as quality assessments and physician's certifications.*

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

SIGNATURE:	DATE: