Pregnancy Health History Form for Progressive Care Chiropractic

Name: _____ Today's Date:_____
Age: _____ Patient Birth date: mm/dd/yyyy _____
E mail address: _____ May we send email appt reminders and important office information? Y / N
Address:_____ City:_____ Zip_____
Phone:(H)_____ (W)_____ (cell) _____
Marital Status: S M W D
Patient's Occupation: _____ Who may we thank for referring you?_____
Family doctors name**/**phone: _____ **May we contact them: Y / N**

Emergency Contact: Name _____Phone#_____
Emergency Contact Relationship to patient_____

WHY THIS FORM IS IMPORTANT: **Our focus is on assisting clients to function optimally, for them to become more self-aware, stronger, healthier and for improved adaptation to everyday stresses. Completion of this form provides us with an improved understanding of your physical, emotional and chemical stresses that can gradually overwhelm the body over time and contribute to health problems. Please complete this form as thoroughly as possible and the doctor will review it with you. Information on this form is strictly confidential and will not be shared without your consent.**

#1 Current Health Concern (if there are no current concerns and this assessment is to ensure optimum health, function and wellness check this box) ☐

 # 2 About Your Pregnancy: (circle answer)
Is this your first pregnancy? **Yes / No**

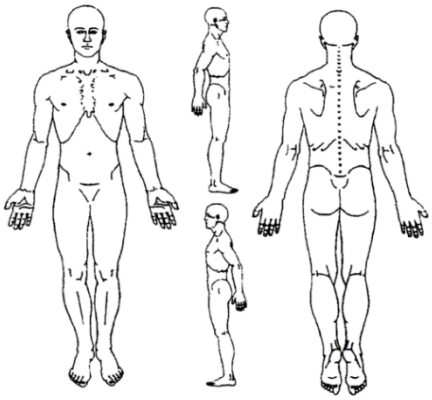
If this is not your first, how many times have you been pregnant? _____
Have you had any complications with previous pregnancies? **Yes / No** (explain if yes)

_____
If you have had miscarriage(s), how far along in your pregnancy did it occur?

_____
Was this pregnancy planned? **Yes / No**
What is the estimated date of delivery? _____
Who is your primary care giver for delivery? Obgyn/ Midwife? Name/Phone: _____
What is your planned location for delivery? Hospital / Home/ Birthing clinic/other
How do you feel about this pregnancy? _____
Do you have a birth plan? **Yes / No**
Any special arrangements for the birth? (planned C-sec, water delivery, birth chair, squat, other)

_____
Have you had any testing? Genetic, blood, ultrasound, amniocentesis, chorionic villi sampling, other)? Dates and reasons: _____
Are you planning on breastfeeding? **Yes / No**
Was your blood pressure prior to pregnancy within normal range, low or high? _____
What is your present blood pressure and when was it last checked? _____
Have you changed your diet/menu since learning of your pregnancy? **Yes / No**
Would you like further information on healthy nutrition for pregnancy? **Yes / No**
Have you smoked prior to or along with this pregnancy? **Yes / No / Quit** _____
Have you had alcohol during this pregnancy? **Yes / No** _____
Have you noticed:
Swelling in the arms or legs? (circle) **Yes / No**

Any other symptoms? Low back pain? **Yes / No** How often? _____



Upper back pain? **Yes / No** How often? _____
Neck pain? **Yes / No** How often?_____
Rib or chest pain? **Yes / No** How often? _____
Any foot pain? **Yes / No** How often? _____
Digestive complaints? Heartburn, constipation? **Yes/ No**
_____
Nausea or vomiting? **Yes / No** Frequency and when?
_____

Arm or hand numbness/tingling? **Yes / No** How often?
_____
Dizziness or lightheadedness? **Yes / No** How often?
_____

Headaches? **Yes / No** How often?_____
Pain radiating down the leg(s)? **Yes / No** How often? _____

Heart palpitations? **Yes / No** How often? _____

If there is pain from anything noted above, rank it on a scale of 1 to 10:
(1 is minimal, 10 is extreme) _____
Circle or describe it's character: **sharp, dull, ache, burning, tingling, throbbing, spasms, other**
_____
When did you notice it?_____
What happened? _____ What relieves?_____
What aggravates?_____
Does it radiate or cause problems elsewhere? _____
Any associated or related concerns? _____
Professionals seen for this? (name) _____
Treatment and results_____
Other health concerns: Please note all other health concerns present or in the past.
_____

Diseases history: (please circle all that apply)
Allergies, Stuffy nose, Runny sinuses, Frequent colds, Lowered resistance, Loss of balance, Difficulty concentrating, Fatigue, Indigestion, Bloating, Appendicitis, Asthma, Bronchitis, Emphysema, Pneumonia, Bleeding disorders, Cancer, Cataracts, Vision changes, Diabetes, Hypoglycemia, Epilepsy, Heart Disease, Hypertension, Migraines, Hepatitis, High cholesterol, Difficulty digestion, Loose stools, Hernia, Herniated Disc, Kidney Disease, Liver disease, Multiple Sclerosis, MTHFR, Osteoarthritis, Rheumatoid arthritis, Osteoporosis, Parkinson's Disease, Thyroid problem, Tonsillitis, Ulcers, Urinary tract infections, Ulcerative colitis Other (list):
_____

#3 Physical stresses
Any significant injuries, falls or traumas during infancy or childhood? **Yes No Unsure**
(if yes please explain) _____
Any significant injuries, falls or traumas (car accidents) during adulthood? **Yes No Unsure**
(if yes please explain) _____
Any hospital visits? **Yes No** Explain_____
Have you had any surgeries, fractures? **Yes No**
Explain and dates _____
Are you in prolonged postures (ex: repetitive work, lifting, sitting, driving) **Yes No Unsure**
(if yes, please explain)_____
Any hobbies that are physically strenuous or have repetitive movements? **Yes No Unsure**
(if yes, please explain)_____

What is your usual exercise routine? _____
Any fractured bones or dislocations? _____
Any vehicle accidents? **Yes No** What happened and when? _____

#4 Chemical Stresses

Are you taking prescription or over-the-counter medications? **Yes / No (**If yes, please indicate what you are taking and why) _____
Are you currently taking supplements? **Yes / No**(if yes, which ones and why?) _____
_____
Do you eat organic? **Yes / No / Occasionally**
Do you use natural or environmentally friendly products in your home? I.E. Cleaning supplies, hair and makeup, etc. **Yes / No** _____

#5 Mental/Emotional Stresses

Since psychological stress has been shown to affect numerous systems and fetal function, please let us know how you are coping with life's stresses. Rank from 1 to 10 with 1 being minimal to 10 being extreme)

Life in general I feel _____ Work and Career I feel _____ Relationships I feel _____
Financial stress I feel _____ Time management I feel ____ Sports & hobbies I feel _____
Health and well-being I feel ____ Quality of sleep I feel ____ About my pregnancy I feel ____
If you are experiencing significant or ongoing stress please explain _____
_____
Do you practice some form of meditation, breath work, other mind-body movement or have a routine to reduce your stress? **Yes /No** Explain _____

#6 Family Health History

Please note any health issues that are present with **family members** such as parents, siblings, significant other or children. Cancer, hypertension, stroke, arthritis, kidney disease, dementia, diabetes, other _____

#7 Why are you here?

People seek chiropractic care for a number of reasons and have certain expectations and perceptions. Please check the goals which apply to you so we can accommodate your wishes.

Improvement in function ___ Pain reduction ___ Relief ___ Improved quality of life ____
Symptom management ____ Healthier immune system ___ Stress reduction ___ Keep me moving___
Optimum function and quality of life ___ Wellness ____ Other_____

CONSENT for examination and care: Please Read Carefully

In order for my health professional as indicated below to make a determination on the suitability of my case for care, I acknowledge and understand that I must complete a thorough evaluation. I do hereby request and consent to the performance of such an evaluation by the person(s) named below, or any party authorized to do so by that person.

I have had the opportunity to discuss with the Doctor of Chiropractic indicated below, or with any party authorized to do so by that Chiropractor, about the nature and purpose of the examination process. I understand that there may be remotely associated risks with examinations, as there are with any and all healthcare treatments. In healthcare, the matter of whether any treatment is appropriate or not is determined by looking at the level of risk and comparing this with the level of expected benefit. I understand that I may ask the doctor to stop the examination at any time. I also understand that by signing this form, the chiropractor continues to be obligated for best practices delivered in my interests.

Name: _____ Date:_____

Signature:_____ **Witness:**_____

Informed Consent for Treatment at Progressive Care Chiropractic, LLC

It has been determined that my case is suitable for chiropractic care.
After my report of findings, I have had the opportunity to discuss with the Doctor of Chiropractic indicated below, or with any party authorized to do so by that Chiropractor, about the nature and purpose of Chiropractic adjustments and other procedures. I understand that there are, however, some risks associated with Chiropractic care, as there are with any and all healthcare treatments. In healthcare, the matter of whether any treatment is appropriate or not is determined by looking at the level of risk and comparing this with the level of expected benefit.
I understand that in rare cases there have been incidents of injury to the vertebral artery during the course of care to the cervical spine by medical doctors, physiotherapist, and chiropractors. However, the proposed mechanism of this injury is reproduced by a wide variety of trivial neck movements such as coughing sneezing, turning your head to look out the back of a car, or having a shampoo at a hair salon. This injury is of concern because it may lead to stroke. The risk of stroke after a cervical adjustment is estimated to be approximately **1 in 1 million.** To put this in perspective, studies that have assessed the risk from interventions a non-chiropractor commonly uses for the same complaints have found the following:
Risk of paralysis or stroke from surgeries or neck pain**: 15, 600 per 1 million**
Risk of death from surgery for neck pain: **6, 900 per 1 million**
Risk of serious gastrointestinal event from a non-steroidal anti-inflammatory drug (e.g. Aspirin, ibuprofen):
1,000 per million
Risk of stroke following a chiropractic adjustment: **1 per 1 million up to 1 per 5 million**
To put this further into perspective, these studies estimate:
Risk of death before the age of 35 due to smoking cigarettes: **1677 per 1 million**
Annual risk for being injured in a car accident is: **13, 333 per 1 million**
Another complication that may arise following a spinal adjustment is a rib fracture, muscle strain, or ligament sprain. These complications are extremely remote and the Doctor of Chiropractic is uniquely trained to assess your spine and adjust in ways that significantly diminish your risk.
I have read and understood the remote risks inherent in undergoing chiropractic care, although, I do not expect the Doctor to be able to anticipate and explain all of the risks that could possibly occur. I wish to rely on the Doctor to exercise judgment during the course of chiropractic care on that basis. I have read and understood the above and I consent to all examinations and care as deemed appropriate by the Doctor of Chiropractic for my present condition, and for any future conditions for which I may seek care.
I realize that I may still ask questions to the Doctor at any time after I sign this consent. I understand that my consent can be withdrawn at any time. I also understand that by signing this form, the chiropractor continues to be obligated for best practices delivered in my interests.

Name: _____ Date: _____

Signature: _____

Notice of Privacy Practices Acknowledgement
Progressive Care Chiropractic, LLC

I understand that under the Health Insurance Portability and Accountability Act **(HIPAA)**, I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____ _____
Patient Name or Legal Guardian (print) Date

_____
Signature