PREGNANCY HEALTH HISTORY (UPDATED)

Name_____ DOB_____ Age_____

Address_____City_____State_____Zip_____

Home Phone _____Work Phone_____Cell Phone _____

SS# _____-_____-_____ E-mail_____

Why have you decided to seek chiropractic care for your pregnancy? (check all that apply)

- o I am currently a patient and have recently become pregnant.
- o I am a returning patient.
- o I am interested in a wellness prenatal program throughout my pregnancy.
- o I have no complaints and wish to have an amazing pregnancy & birth experience with the help of chiropractic.
- o I have specific concern(s) & wish to have an amazing pregnancy & birth experience with the help of chiropractic.
- o I have specific concern(s) & only want to feel better (not a wellness program throughout pregnancy).

SINCE YOUR LAST VISIT…

1) Have there been any changes to your health? YES NO Explain_____
2) Have there been any changes to your family history? YES NO Explain_____
3) Have there been any traumas, accidents or surgeries? YES NO Explain_____

_____

Prenatal History: *(circle, highlight or write where applicable)*

1) Is this your first pregnancy? Yes No How many other births have you had? _____
2) How many weeks pregnant are you?_____wks What is your estimated due date? _____
3) If you are in your 3rd trimester, what position is your baby in? Vertex (head down) Breech (see below)
4) Were there any challenges trying to conceive for this pregnancy? Yes No _____
5) Where do you plan on delivering? Home Birthing Center Hospital Other_____
6) Who is your birth care provider? Lay Midwife Nurse Midwife OBG Name_____
7) Who will you have with you at birth for support?_____
8) Have you put together a birth plan? Yes No
9) Have you experienced any traumas (accidents, falls) during this pregnancy? Yes No
   Please describe:_____
10) Have you had any evaluation procedures (ultrasound, amniocentesis, chorionic villus sampling)? Yes No
   Dates / frequency & reasons:_____
11) Have there been any stressful events in your life during this pregnancy? Yes No
   Please describe:_____
12) What are your most significant concerns associated with this birth?_____
13) Are you taking any prenatal supplements? Yes No (multi, fish oil, vit D)_____
14) Any medications during this pregnancy? Yes No _____

If this visit is concerning a breech presentation, please complete the following:

a. What position is your baby in now? Transverse Complete Footling Frank Kneeling Other_____
b. Was it confirmed by ultrasound? Yes No When was the last test to confirm the baby's position?_____
c. At what gestational week did you first learn your baby was breech?_____Wks
d. Have you tried any procedures or maneuvers yet? Yes No Explain:_____
e. Are you familiar with the chiropractic Webster Technique? Yes No

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1st Concern (if any)_____

Been a problem for: (please specify #) _____Day(s) _____Week(s) _____Month(s) _____Year(s)

a. Quality of symptom is: Sharp Dull Numb Tingling Burning Stiff Other_____

b. Condition came on: Sudden Gradual How:_____

c. It is: Constant / Frequent ***(daily)*** / Intermittent ***(several/wk)*** / Occasional ***(1/wk or less)***

d. Feels worse in: AM Noon PM In Bed It Varies It's getting: Better Worse No Change

e. Rate on a scale of 1-10 *(10 = worst)* at its worst:_____

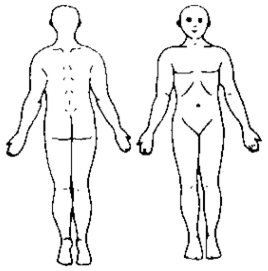
f. What makes it better?_____

g. What makes it worse?_____

h. Have you seen anyone for this? Yes No Who?_____

i. How does it interfere with your life (sleep, work, play, driving, lifting, etc.)_____

Mark areas below



Other Concerns *(Please briefly describe)*_____

_____

Please rate the following as (P) Poor, (G) Good or (E) Excellent:

Diet – P G E Sleep – P G E Mental State – P G E General Health – P G E

Wellness Profile: Chiropractic care affects more than just muscles, joints and how we feel. Chiropractic helps our bodies function at a higher level which increases our overall health and wellness. Please share with us what health goals you hope to achieve. *(Circle as many goals as you wish)*

More Energy	Better Sleep	Freedom from Pain
Easier Breathing	Improved Posture	Improved Nutrition & Diet
Eliminate Medications	Improved Overall Health	Stress Reduction
Better Concentration	Stronger Immune System	Other_____

Fees & Care Plans:

Initial Exam	$95-$125
Adjustments	$45-$60
Re-Exam	$60

On your second visit, Dr. Sullivan will review the results of your exam and go over your care plan. We will also review your financial responsibilities regarding your care. If you have insurance, please read the section below.

Insurance: We used to be 'in network' with many insurance companies however we found being 'out of network' offered most of our patients' *better* coverage and *fewer* restrictions. We can work with most insurance companies to submit claims electronically on your behalf. Currently we are ***'in network'*** with **Medicare** and are considered ***'out of network'*** for **all others**. You may call the (800) number on the back of your card to check your coverage; however, we will call to verify your chiropractic benefits and discuss them with you on your second visit when the doctor reviews your care plan.

MEDICARE – Medicare has limited chiropractic coverage; however, they ***DO NOT*** contribute towards ***exams*** in a chiropractic office. If you are a returning patient, your initial visit will most likely include the exam ($95) and an adjustment ($45).

MEDICAID – Currently Medicaid **DOES NOT** offer ANY chiropractic benefits. The fees listed above will be your full financial responsibility if you have Medicaid or any Medicaid type policy.

I understand that I am directly and fully responsible to BC Family Chiropractic for all fees associated with chiropractic care whether or not paid by insurance. If I have insurance, I authorize and assign all insurance benefits payable to me for services rendered if BC Family Chiropractic accepts assignment on my behalf. I authorize use of my signature below on all insurance submissions. Copies of any x-ray reports will be released upon written request, however the original films are the legal property of this practice and that by law the doctor must retain these films for a period of no less than 7 yrs.

The above information is true and accurate to the best of my knowledge.

Patient Name	Patient Signature	Date	Dr. Initials

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ACTIVITIES OF DAILY LIVING

In order to properly assess your condition, we must understand how much your health problems have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition currently.**

		0	1	2	3	4
1)	**Pain Intensity:**	None	Mild	Moderate	Severe	Unbearable
2)	**Frequency of Pain:**	None	25% of the day	50% of the day	75% of the day	Constant
3)	**Lifting:**	No Pain w/ Heavy Weight	Increased Pain w/ Heavy Wt.	Increased Pain w/ Moderate Wt.	Increased Pain w/ Light Wt.	Increased Pain w/ Any Wt.
4)	**Walking:**	No Pain w/ Any Distance	Increased Pain After 1 Mile	Increased Pain After ½ Mile	Increased Pain After ¼ Mile	Increased Pain w/ Any Distance
5)	**Standing:**	No Pain After Several Hours	Increased Pain After Several Hours	Increased Pain After 1 Hour	Increased Pain After ½ Hour	Increased Pain w/ Any Standing
6)	**Travel:** (Driving)	No Pain on Long Trips	Mild Pain on Long Trips	Moderate Pain on Long Trips	Moderate Pain on Short Trips	Severe Pain on Short Trips
7)	**Work:**	Do Usual Work + Unlimited Extra	Do Usual Work But No Extra	Can do 50% of Usual Work	Can do 25% of Usual Work	Cannot Work
8)	**Sleeping:**	Perfect Sleep	Mildly Disturbed	Moderately Disturbed	Severely Disturbed	Totally Disturbed
9)	**Personal Care:** (Washing, Dressing, etc.)	No Pain	Mild Pain	Moderate Pain	Severe Pain	Unbearable Pain
10)	**Recreation:**	Can do All Activities	Can do Most Activities	Can do Some Activities	Can do Few Activities	Cannot do Any Activities

Patient Signature:_____ Date:_____ Score:_____