

# 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)

- I am currently a patient and have recently become pregnant.
- I am a returning patient.
- I am interested in a wellness prenatal program throughout my pregnancy.
- I have no complaints and wish to have an amazing pregnancy & birth experience with the help of chiropractic.
- I have specific concern(s) & wish to have an amazing pregnancy & birth experience with the help of chiropractic.
- 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 3<sup>rd</sup> 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

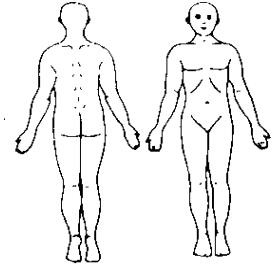
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**1<sup>st</sup> Concern (if any)** \_\_\_\_\_

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.**

- 1) **Pain Intensity:**    0-----1-----2-----3-----4  
                                  None                    Mild                    Moderate                    Severe                    Unbearable
- 2) **Frequency of Pain:**    0-----1-----2-----3-----4  
                                  None                    25% of the day                    50% of the day                    75% of the day                    Constant
- 3) **Lifting:**    0-----1-----2-----3-----4  
                                  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:**    0-----1-----2-----3-----4  
                                  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:**    0-----1-----2-----3-----4  
                                  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:**    0-----1-----2-----3-----4  
   (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:**    0-----1-----2-----3-----4  
                                  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:**    0-----1-----2-----3-----4  
                                  Perfect Sleep                    Mildly Disturbed                    Moderately Disturbed                    Severely Disturbed                    Totally Disturbed
- 9) **Personal Care:**    0-----1-----2-----3-----4  
   (Washing,  
Dressing, etc.)                    No Pain                    Mild Pain                    Moderate Pain                    Severe Pain                    Unbearable Pain
- 10) **Recreation:**    0-----1-----2-----3-----4  
                                  Can do All  
Activities                    Can do Most  
Activities                    Can do Some  
Activities                    Can do Few  
Activities                    Cannot do Any  
Activities

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Score: \_\_\_\_\_

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