INNATE CHIROPRACTIC & WELLNESS

PREGNANCY HEALTH HISTORY

Today's Date_____

ABOUT THE EXPECTING MOTHER

Name _____ Age _____ Date of Birth _____

Height _____ Weight _____

Home Address _____City _____ State _____ Zip _____

Home phone (_____) _____ Cell phone (_____) _____

Occupation _____ E-mail _____

Emergency Contact Name_____ Emergency Contact phone (_____)_____

Birth Provider's Name _____ Phone (_____)_____

Birth Provider's Address _____ City _____ State _____ Zip _____

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

REASON FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel we can address for you during your pregnancy? _____

_____

What is your chief complaint? _____

Date of Onset: _____

On a scale of 0-10, with 0 meaning perfect and 10 meaning hospitalization, please indicate how you feel:

0 1 2 3 4 5 6 7 8 9 10

Onset of symptoms was: ❑ Sudden ❑ Gradual ❑ Injury ❑ Chronic ❑ Auto

❑ Other _____

Duration of symptoms: ❑ Minutes ❑ Hours ❑ Days ❑ Months ❑ Years

❑ Other _____

Pattern of symptoms: ❑ Constant (100%) ❑ Frequent (75%) ❑ Intermittent (50%) ❑ Occasional (25%) ❑ Cyclical

What makes your symptoms better? _____

What makes your symptoms worse? _____

Are your symptoms affecting your quality of life? ❑ Yes ❑ No

Check all that apply

❑ Work	❑ Exercise/Sports	❑ Walking
❑ Social Activities	❑ Sleep	❑ Attention/Focus
❑ Relationship	❑ Eating	❑ Daily Routine

Please describe how these concerns affect you. _____

_____

Have you had anything like this before? ❑ Yes ❑ No

If so, when? _____

Any other health concerns? _____

EXPECTATIONS OF CARE

The primary system in the body, which coordinates health, is the NERVOUS SYSTEM. The vertebrae (bones of the spinal column) surround and protect the delicate NERVOUS SYSTEM. A MISALIGNMENT in the SPINE and NERVOUS SYSTEM is a condition called a VERTEBRAL SUBLUXATION. A VERTEBRAL SUBLUXATION results in nerve malfunction, which results in less communication between the affected NERVES and the function of the BODY.

Vertebral Subluxations can have Physical, Emotional and Chemical causes and effects.

The information below will help us to see the types of **PHYSICAL, EMOTIONAL & CHEMICAL** stresses you have been subjected to, how they may relate to your present spinal, nerve and health status and whether they may have caused **Vertebral Subluxations** to occur.

I would like to experience the following benefits from Chiropractic Care:

Check all that apply
- ❑ Symptomatic relief of pain or discomfort
- ❑ Correction of the cause of the problem as well as relief of symptoms
- ❑ Prevention of future problems
- ❑ Healthier spine and nerve system
- ❑ Optimal health on all levels
- ❑ OTHER_____

PREGNANCY & BIRTH

During pregnancy, has the mother:

❑ Experienced any significant illnesses, difficulties, or trauma? _____

❑ Taken any drugs/medications? _____

❑ Smoked or consumed alcohol? _____

❑ Received Ultra-Sounds: ❑ Yes ❑ No How many? _____ Type of Ultra-Sounds? ❑ 3D ❑ 4D

Has the sex of the baby been determine? ❑ YES ❑ NO If YES are you having a ❑ Girl or ❑ Boy

Estimated Due Date: _____

Was it determined that the child was breech or otherwise malpositioned? ❑ No ❑ Yes _____

First Pregnancy ❑ YES ❑ NO If NO, how many pregnancies have you had? _____

Type of Previous Birth:

❑ Home birth or ❑ Hospital birth Via: ❑ Vaginal ❑ Water birth ❑ Caesarean

Type of Birth you are currently planning:

❑ Home birth or ❑ Hospital birth Via: ❑ Vaginal ❑ Water birth ❑ Caesarean

Are/Have you:

❑ Been exposed to second hand smoke?

❑ Taken antibiotics? Explain _____

❑ Currently taking medication? Explain _____

❑ Currently taking any supplements (Vitamins/Probiotics)? Explain _____

❑ Had allergies (seasonal, food, etc)? Explain _____

-What treatments have you used? _____

PHYSICAL STRESS

Are/Have you:

❑ Been hospitalized? Explain: _____

❑ Had a severe trauma? Explain: _____

❑ Been in an automobile accident? Explain: _____

❑ Fractured a bone or dislocated a joint? Explain: _____

❑ Had a chronic illness? Explain: _____

❑ Had surgery? Explain: _____

What physical activities do you participate in? _____

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? _____

Have you consulted or do you regularly consult any of the following providers?

Check all that apply	❑ Medical Physician	❑ Naturopath	❑ Acupuncturist	❑ Homeopath
	❑ Massage Therapist	❑ Psychotherapist	❑ Energy Healer	❑ Other

Reason _____

_____

_____

FINANCES

Payment in full is expected on all FIRST VISIT services. All other fees are to be paid at time of service until other arrangements have been made and agreed upon in writing.

Please indicate your method of payment. ❑ Cash ❑ Check ❑ Credit Card

**Insurance coverage isn't necessary in our office. Our fees are constructed to give you the care you need. We are much more concerned about you than we are about your coverage.

PLEASE READ AND SIGN

1. I acknowledge Innate Chiropractic & Wellness has informed me they are not accepting insurance assignment. Therefore, they cannot guarantee claims for any services rendered to me by Dr. Rachel Settles. I clearly understand and agree all services rendered are charged directly to me and I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. All services rendered will be paid in full each visit, or via monthly auto draft.
2. I have been informed that a copy of Innate Chiropractic & Wellness *"Notice of Privacy Practices for Protected Health Information (HIPAA)"* brochure is available for my review both at the office
3. I consent to receive communication from Innate Chiropractic & Wellness via email, postal mail, text and telephone messaging in connection with my care. ❑ Yes ❑ No
   If I should withdraw my consent, I will notify the office in writing.
4. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if my care is suspended or terminated, any fees for professional services rendered will become immediately due and payable.

The information I have provided on this case history form is true and accurate to the best of my knowledge.
I give Dr. Rachel Settles, of Innate Chiropractic & Wellness, permission to render care to me today. This initial visit includes a health history consultation, chiropractic exam and evaluation, and any initial care that is determined to be clinically necessary and mutually agreed upon.

Name: (Printed) _____

Signature _____ Date: _____

Dr. Signature _____ Date: _____

Thank you for choosing Innate Chiropractic & Wellness.

We look forward to helping you.