EXPERIENCE life CHIROPRACTIC

Pregnancy Questionnaire

CONFIDENTIAL INFORMATION

First Name: Last Name: Date:

Street Address: City, State, Zip:

Phone Number: Email:

SSN: Age: Birthdate: Sex: M F

Marital Status: Occupation:

Number of Children: Children's names and ages:

Emergency Contact: Relation: Emergency Phone:

How did you hear about us?

Who is your primary care physician?

Date and reason for your last doctor visit:

Are you receiving care from any other health professionals? Yes No

-If yes, please name them and their specialty:

BIRTH EXPERIENCE

Is this your first pregnancy? Yes No

-If not, please tell us about your previous pregnancy and/or birth experience(s): (Durations, interventions, etc)

Do you plan to follow the same plan as your previous delivery? Yes No

-If not, what would you like to change?

CONCEPTION & EARLY PREGNANCY

When is your expected or calculated due date?

Did you have any difficulty conceiving? Yes No

-If yes, please explain:

Have you used any form of hormonal or oral contraceptives? Yes No

-If yes, which ones, and for how long?

When was your last menstrual cycle?

What was your pre-pregnancy weight? Current weight?

Have you experienced morning sickness? Yes No

-If yes, please explain:

CURRENT HEALTH CONDITIONS

What types of exercise(s) are you currently performing?

Please tell us about your current diet, and any dietary restrictions:

Have you taken any medications or supplements during your pregnancy? Yes No
-If yes, please explain:

Have you had any slips, falls, or other physical traumas during this pregnancy? Yes No
-If yes, please explain:

Have you had any major emotional stressors during your pregnancy? Yes No
-If yes, please explain:

Emotional Stresses & Challenges

Please rate your STRESS for each:

	None		*Moderate*		*High*		*None*		*Moderate*		*High*
Home	1	2	3	4	5	Money	1	2	3	4	5
Work	1	2	3	4	5	Health	1	2	3	4	5
Life	1	2	3	4	5	Family	1	2	3	4	5

YOUR BIRTH PLAN

Your top three goals for this pregnancy:
1._____
2._____
3._____

Do you currently have a birth plan? Yes No
-If yes, please explain:

Are you taking any pre-natal or birthing classes? Yes No
-If yes, please explain:

Who is your OB/GYN or midwife? Will they be present for delivery? Yes No

Do you intend to have a doula or birth coach present? Yes No If yes, doula's name:

Do you wish to have a vaginal labor and delivery? Yes No
-If not, what concerns do you have?

YOUR POST-BIRTH PLAN

Do you plan on breastfeeding your child? Yes No

What do you intend to do for vaccines?

Is there anything else you'd like to tell us about your pregnancy or birth plan?

What would you like to gain from chiropractic care during your pregnancy?

Are there any burning questions you want to be sure to ask today?

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 disclosure.
- 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 and Accountability Act of 1996 (HIPAA), I have certain rights to regular 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.

Patient Name (printed):	Relationship to Patient:
Signature:	Date:

INFORMED CONSENT

We encourage and support a shared decision making process between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgably give or withhold your consent.

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

Adjustments are made by chiropractors in order to correct or reduce subluxations. **Vertebral subluxation** is a disturbance in the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

In addition to the benefits of chiropractic care, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. In addition there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I HAVE READ THE ABOVE. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY ATHORIZE DR. SHEENA NAGELI TO PROCEED WITH CHIROPRACTIC CARE DATED THIS _____ DAY OF _____ 20_____.

Patient Signature:	Doctor's signature:

EXPERIENCE life CHIROPRACTIC

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