New Patient Pregnancy Intake Form

parker river chiropractic & wellness

Name _____ **Today'sDate**___

Address _____ **City** _____ **State** ____ **Zip Code** _____

Home Phone _____ **Cell Phone** _____**Work Phone** _____

Email _____ **Date of Birth** _____ **Age** _____

Height _____ **Weight** _____ **Marital Status (circle)** Single Married Divorced Widowed

Occupation _____ **How did you hear about our office** _____

Emergency Contact _____ **Relationship to Patient** _____

Contact Home Phone _____ **Cell Phone** _____

Health Insurance Company _____ **Member ID** _____

Name of Insured _____ **Insured's Date of Birth** _____

Reason for Visit _____

When did this condition begin _____ **Have you had it before** Yes No

Is this condition getting worse Yes No **How do you rate the pain 1 (least pain) to 10 (severe pain)**_____

Type of pain (circle) Achy Tight Tense Sharp Stiff Stabbing Throbbing Burning Tingling Numb Dull

Nature of the pain (circle) Constant Frequent Intermittent Episodic

What makes the pain better _____**What makes the pain worse** _____

Does your pain interfere with (circle) Work Sleep Recreation Activities of Daily Living Everyday Life

Have you seen anyone for this condition _____ **Results** _____

Is the condition (circle) Job related Auto Accident Work Accident Slip/Fall Other

Date of Accident _____ **Has the accident been reported** _____

List any other complaints/pain _____

Any difficulty performing (circle) Dressing Showering Sitting Standing Walking Lifting Driving Sleeping

List any supplements you are currently taking _____

List any medications you are currently taking _____

List any allergies you have (seasonal, medication, food, etc.) _____

List any surgeries you have had _____

List any accidents/injuries/broken bones _____

Have you been to a chiropractor before _____ **Where** _____ **Last visit** _____

Do you currently smoke? _____ **How many per day?** _____ **Are you a former smoker?** _____

How many alcoholic drinks per day _____ **Recreational drug use** _____

Family History (circle) Cancer High Blood Pressure Diabetes Heart Attack Stroke Other _____

GENERAL SYMPTOMS **Please check all symptoms that you currently have or have had**

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Anorexia/Bulimia
- ☐ Arthritis
- ☐ Bleeding Disorders
- ☐ Cancer/Tumors
- ☐ Chemical Dependency
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting or Seizures
- ☐ Fibromyalgia
- ☐ Forgetfulness
- ☐ Gout
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ Multiple Sclerosis
- ☐ Nervousness
- ☐ Night Sweats
- ☐ Osteoporosis
- ☐ Paraylsis
- ☐ Psychiatric Care
- ☐ Stroke
- ☐ Tiredness
- ☐ Thyroid Problems
- ☐ Weight Change (dramatic)

EYE, EAR, NOSE, THROAT

- ☐ Blindness
- ☐ Blurred Vision
- ☐ Cataracts
- ☐ Double Vision
- ☐ Floaters
- ☐ Glaucoma
- ☐ Earache
- ☐ Hearing Loss
- ☐ Ringing in the ears
- ☐ Ear Infections
- ☐ Allergies/Hayfever
- ☐ Post Nasal Drip
- ☐ Nosebleeds
- ☐ Sinus Problems
- ☐ Bleeding Gums
- ☐ Dental Problems
- ☐ Chronic Cough
- ☐ Difficulty Swallowing
- ☐ Slurred Speech
- ☐ Sore Throat
- ☐ Vertigo (Dizziness)

EXERCISE

- ☐ None
- ☐ Mild 1-2x/wk
- ☐ Moderate 3x/wk
- ☐ Daily
- ☐ Heavy (daily and intense)

CARDIOVASCULAR

- ☐ Chest Pain
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Irregular Heartbeat
- ☐ Low Blood Pressure
- ☐ Pacemaker
- ☐ Poor Circulation
- ☐ Swelling of Ankles
- ☐ Varicose Veins
- ☐ Stroke
- ☐ Heart/Lung Defect

RESPIRATORY

- ☐ Asthma
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Mononucleosis
- ☐ Emphysema
- ☐ COPD
- ☐ Shortness of Breath

GASTROINTESTIONAL

- ☐ Poor Appetite
- ☐ Black/Bloody Stool
- ☐ Bloating/Gas
- ☐ Colitis/IBS
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive Hunger
- ☐ Excessive Thirst
- ☐ Hemorrhoids
- ☐ Hernia
- ☐ Indigestion
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Loss of Bowel Control
- ☐ Nausea
- ☐ Reflux
- ☐ Stomach Pain
- ☐ Ulcers
- ☐ Vomiting
- ☐ Rectal Bleeding

FAMILY HISTORY

- ☐ Heart Disease _____
- ☐ Cancer _____
- ☐ Diabetes _____
- ☐ Stroke _____
- ☐ Neurological Disorder _____
- ☐ Other _____

HABITS

- ☐ Smoking Pack/day _____
- ☐ Alcohol Drinks/wk _____
- ☐ Coffee/Caffeine Cups/day ____
- ☐ High Stress Level
- ☐ Reason _____

GENITO-URINARY

- ☐ Bladder Trouble
- ☐ Difficulty Starting/Stopping Flow
- ☐ Frequent Urination
- ☐ Incontinence
- ☐ Painful Urination

MEN ONLY

- ☐ Erection Difficulties
- ☐ Testicular Lumps
- ☐ Prostate Problems

WOMEN ONLY

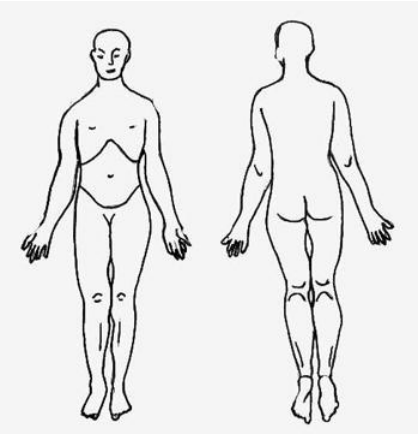
- ☐ Abnormal Pap Smear
- ☐ Abnormal Periods
- ☐ Breast Lumps/Pain
- ☐ Cysts/Tumors
- ☐ Discharge
- ☐ Dysmenorrhea
- ☐ Endometriosis
- ☐ Extreme Cramps
- ☐ Hot Flashes
- ☐ Miscarriage
- ☐ Spotting

Date of last period _____
What is your due date? _____
Number of Children _____
Last Mammogram _____

MENTAL/EMOTIONAL

- ☐ Anxiety
- ☐ Psychotic episodes
- ☐ Obsessive compulsive disorder
- ☐ Anger/aggression
- ☐ Attention Deficit
- ☐ Mental Disorders

Please outline on the diagram the area of your discomfort



Webster Technique Agreement

□ I acknowledge that the Webster Technique is a specific chiropractic analysis and diversified adjustment. The goal of the adjustment is to reduce the effects of sacral/pelvic subluxation and/or SI joint dysfunction. In doing so neuro-biomechanical function in the pelvis is improved.

□ I acknowledge that in a theoretical and clinical framework of the Webster Technique in the care of pregnant women, sacral subluxation may contribute to difficult labor for the mother (i.e., dystocia). Difficult labor is caused by inadequate uterine function, pelvic contraction, and baby mal-presentation. The correction of sacral subluxation may have a positive effect on the causes of difficult labor.

□ I acknowledge that sacral misalignment may contribute to these primary causes of difficult labor via uterine nerve interference, pelvic misalignment and the tightening of specific pelvic muscles and ligaments. The resulting tense muscles and ligaments and their abnormal effect on the uterus may prevent the baby from comfortably assuming the best possible position for birth.

□ I understand that this sacral/pelvic analysis and adjustment may be used on all weight bearing spines: male, female, pregnant or not pregnant.

□ I acknowledge that this is not a breech turning or in utero-constraint technique

By signing this form, I understand the purpose of the Webster Technique and I agree to have the doctor perform the technique on me at her discretion.

Name _____ Date _____

Authorization for the Release of Medical Records

Authorized Release of Records to Primary Care Physician

Patient Name _____ Date of Birth _____

I hereby authorize Parker River Chiropractic & Wellness to release health care information regarding my treatment to the physician listed below. I understand that records may be released while I am under care per my request to my physician.

Primary Care Provider Information

Doctor Name/Practice Name _____
Address _____
City _____ State _____ Zip _____
Phone _____ Fax _____

Patient Signature_____

Authorized Release of Medical Records from other Providers

I hereby authorize Parker River Chiropractic & Wellness to obtain any of the following medical records from my previous or concurrent medical providers: X-ray, MRI, CT films and reports, SOAP notes, prescriptions, lab tests and any other necessary medical records.

I hereby authorize the following medical facilities to release medical information pertinent to the management of my health.

Doctor Name/Facility Name _____
Address _____
City _____ State _____ Zip _____
Phone _____ Fax _____

Patient Signature_____

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INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination tests, diagnostic x-ray(s) and physical therapy techniques, on myself (or on the patient named below for which I am legally responsible) which are recommended by the Doctor(s) of Chiropractic at Parker River Chiropractic & Wellness.

I understand that, as with any health care procedure, there are certain complications, which may arise during a chiropractic adjustment. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, are in my best interest.

I have had an opportunity to discuss with the doctor at Parker River Chiropractic & Wellness and/or with office personnel, the nature, purpose and risks of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.
I have read ( ) or have had read to me ( ) the above explanation of the chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

_____ _____
Signature of Patient or Guardian Date

ASSIGNMENT OF INSURANCE BENEFITS

I request payment of insurance and/or Medicare benefits be made on my behalf to Parker River Chiropractic & Wellness. If these payments are made out to me directly, I grant the Parker River Chiropractic & Wellness the full power and authority in my name and stead to endorse any and all checks, drafts of money orders.

I understand all copayments are due at the time of service.

I understand there is no guarantee that my insurance company or pre-paid health plan will cover or pay for all of my charges. I understand that I am financially responsible for any treatment or balances not paid by my insurance company.

_____ _____
Signature of Patient of Guardian Date

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge receipt of Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to conduct, plan and direct my treatment, obtain payment from third party payors and conduct normal healthcare operations such as quality assessments and accreditation.

_____ _____
Signature of Patient of Guardian Date