

PDR
Date: _____
Time: _____



Pregnant New Practice Member Application

Name _____ Date of Birth ____ / ____ / ____ Age _____ Male / Female

Address _____ City _____ State _____ Zip _____

Phone (Cell) _____

Email Address _____

Insurance Provider (circle): BCBS UHC Aetna Medicare Other _____

Spouse's Name _____ Number of Children _____

Who may we thank for referring you? _____

HISTORY OF PREGNANCY(s)

Conception + Early Pregnancy

Due date: _____ / _____ / _____ How far along: _____ Gender(s): _____

Did you have difficulty conceiving? Yes No

If yes, please explain: _____

Where do you plan to deliver? Home Birth Center Hospital Other: _____

Previous Birth Experience

Is this your first pregnancy? Yes No If no, how many pregnancies have you had? _____

Please circle ALL that apply to your previous pregnancy and / or birth experience(s):

- | | | |
|-----------------------------------|--------------|------------------------------|
| Preterm labor | Constipation | Tearing – What Degree? _____ |
| Malpositioning | Sciatica | Episiotomy |
| Hyperemesis Gravidarum | Preeclampsia | Prolapse |
| Symphysis Pubis Dysfunction (SPD) | Eclampsia | Diastasis Recti |

Where did your previous births take place (home, birth center, hospital, etc.)? _____

For Each Pregnancy

How long was your labor? _____

How long did you push? _____

Did you receive an epidural? Yes No

If Yes, did you ever experience symptoms related to the epidural (i.e. back pain, numbness, paralysis, etc.)?

Was your labor spontaneous or was induction required? _____

Were any interventions used? Yes No

If Yes, which? C-Section Vacuum Delivery Forceps Delivery

Current Health Conditions

What types of exercises are you currently performing (yoga, spinning babies, hypnobabies, etc.)?

Have you had any slips, falls, hospitalizations or other physical traumas during this pregnancy? Yes No

If yes, please explain: _____

Have you ever had a significant injury to your sacrum, coccyx, pelvis, hip, or any other significant injury or medical history that could affect your pregnancy or childbirth? Yes No

If yes, please explain: _____

Have you had any major emotional stressors during the pregnancy? Yes No

If yes, please explain: _____

After 32nd Week of Pregnancy ONLY

Position of baby (circle one):

- Head down Transverse
- Breech Unknown

Confirmed by and when?

Palpation – Date ____/____/_____
 Ultrasound – Date ____/____/_____

LIST THE HEALTH CONCERNS THAT BROUGHT YOU INTO THIS OFFICE

Health Concerns (list according to severity)	Rate of Severity (0=no pain, 10=unbearable)	When did this problem begin?	Have you had the problem before? When?	Are symptoms constant (C) or intermittent (I)?
Primary _____	_____	_____	_____	_____
Second _____	_____	_____	_____	_____
Third _____	_____	_____	_____	_____
Fourth _____	_____	_____	_____	_____

Have you seen other doctors for these conditions? Yes No

If yes: ____ Chiropractor ____ Medical Doctor Other: _____
 Who? _____ When? _____ Results? _____

PLEASE MARK “P” FOR IN THE PAST OR MARK “C” FOR CURRENTLY HAVE

- | | | |
|---|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Jaw/TMJ Pain | <input type="checkbox"/> Depression | <input type="checkbox"/> Epilepsy/Convulsions |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Allergies | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Sinus Issues | <input type="checkbox"/> Disc Problems |
| <input type="checkbox"/> Arm Pain | <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Muscle Spasms |
| <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> Thyroid Issues | <input type="checkbox"/> Poor Posture |
| <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Asthma | <input type="checkbox"/> Skin Problems |
| <input type="checkbox"/> Lower Back Pain | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Sexual Dysfunction |
| <input type="checkbox"/> Hip/Leg Pain | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Sleep Problems |
| <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Nausea | <input type="checkbox"/> Tight/Sore Muscles |
| <input type="checkbox"/> Foot Pain | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Sports Injury |
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Digestive Issues | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Arthritis/Joint Pain |
| <input type="checkbox"/> Ringing in the Ears | <input type="checkbox"/> Constipation | <input type="checkbox"/> GERD/Gastric Reflux |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Numb/Tingling in Arms/Hands |
| <input type="checkbox"/> Loss of Energy | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Numb/Tingling in Legs/Feet |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Bladder Problems | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Double/Blurry Vision | <input type="checkbox"/> Menstrual Problems | <input type="checkbox"/> High/Low Blood Pressure |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Difficulty Breathing |
- Stroke Cancer Heart Attack Spinal Surgery Spinal Bone Fracture Scoliosis Diabetes Arthritis Seizures

List ALL surgical operations and years: _____

List any other injuries to your spine, minor or major, that the Doctor should know about: _____

List ALL over the counter and prescription medications you are on and the reason for each: _____

Have you ever been in an auto accident? List all: _____

Have you ever been knocked unconscious? Yes No Fractured a bone? Yes No

If yes to either of the above, please describe: _____

Other trauma: _____

Chemical & Environmental Exposure (please rate your CONSUMPTION for each: 1 = None, 5 = High)

Smoking	1	2	3	4	5	Dairy	1	2	3	4	5
Alcohol	1	2	3	4	5	Gluten	1	2	3	4	5
Sugar	1	2	3	4	5	Processed Foods	1	2	3	4	5
Caffeine	1	2	3	4	5	Recreational Drugs	1	2	3	4	5

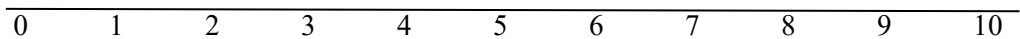
Stresses & Challenges (please rate your STRESS for each: 1 = None, 5 = High)

Home	1	2	3	4	5
Work	1	2	3	4	5
Money	1	2	3	4	5
Health	1	2	3	4	5
Family	1	2	3	4	5
Life	1	2	3	4	5

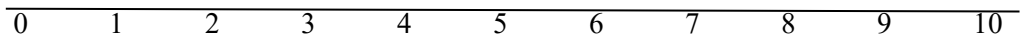
QUADRUPLE VISUAL ANALOGUE SCALE

Please circle the number that best describes the question asked, 0=no pain and 10=unbearable. If you have more than one complaint, please answer each question for each individual complaint and indicate the score of each complaint.

1. How would you rate your pain RIGHT NOW?

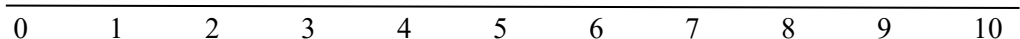


2. What is your typical or AVERAGE pain?



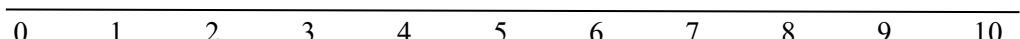
3. What is your pain level at BEST? (How close to 0 does your pain get at its best?)

What percentage of your awake hours is your pain at its BEST? _____%



4. What is your pain level at its WORST? (How close to 10 does your pain get at its worst?)

What percentage of your awake hours is your pain at its WORST? _____%



Practice Member name (that's you!): _____ Date: _____

ACTIVITIES OF LIFE

Please circle how your current condition is affecting your ability to carry out activities that are routinely part of your life:

<u>ACTIVITY:</u> _____	<u>EFFECT:</u>			
Carrying Groceries	No Effect	Painful (can do)	Painful (limits)	Unable to perform
Sit to Stand	No Effect	Painful (can do)	Painful (limits)	Unable to perform
Climbing Stairs	No Effect	Painful (can do)	Painful (limits)	Unable to perform
Pet Care	No Effect	Painful (can do)	Painful (limits)	Unable to perform
Driving	No Effect	Painful (can do)	Painful (limits)	Unable to perform
Extended Computer Use	No Effect	Painful (can do)	Painful (limits)	Unable to perform
Household Chores	No Effect	Painful (can do)	Painful (limits)	Unable to perform
Lifting Children	No Effect	Painful (can do)	Painful (limits)	Unable to perform
Dressing	No Effect	Painful (can do)	Painful (limits)	Unable to perform
Shaving	No Effect	Painful (can do)	Painful (limits)	Unable to perform
Sexual Activities	No Effect	Painful (can do)	Painful (limits)	Unable to perform
Sleep	No Effect	Painful (can do)	Painful (limits)	Unable to perform
Static Sitting	No Effect	Painful (can do)	Painful (limits)	Unable to perform
Static Standing	No Effect	Painful (can do)	Painful (limits)	Unable to perform
Walking	No Effect	Painful (can do)	Painful (limits)	Unable to perform
Washing/Bathing	No Effect	Painful (can do)	Painful (limits)	Unable to perform
Sweeping/Vacuuuming	No Effect	Painful (can do)	Painful (limits)	Unable to perform
Dishes	No Effect	Painful (can do)	Painful (limits)	Unable to perform
Laundry	No Effect	Painful (can do)	Painful (limits)	Unable to perform
Yard work	No Effect	Painful (can do)	Painful (limits)	Unable to perform
Garbage	No Effect	Painful (can do)	Painful (limits)	Unable to perform
Concentration (Reading)	No Effect	Painful (can do)	Painful (limits)	Unable to perform
Other: _____	No Effect	Painful (can do)	Painful (limits)	Unable to perform
Other: _____	No Effect	Painful (can do)	Painful (limits)	Unable to perform

List your Top 3 Health Goals:

1. _____
2. _____
3. _____

List your Top 3 Pregnancy + Delivery Goals:

1. _____
2. _____
3. _____

FAMILY HEALTH HISTORY

This form is to assist the Doctor by providing past health history information for their review.

CONDITION	SPOUSE	SON	DAUGHTER	MOTHER	FATHER
Headaches					
Neck Pain					
Jaw/TMJ Pain					
Shoulder Pain					
Back Pain					
Hip/Leg Pain					
Arthritis/Joint Pain					
Ear Infections					
Hearing Loss					
Dizziness					
Loss of Energy					
Nervousness					
Blurred/Double Vision					
Anxiety					
ADD/ADHD					
Depression					
Allergies					
Sinus Issues					
Thyroid Problems					
Asthma					
Breathing Problems					
Heart Problems					
High/Low Blood Pressure					
Stomach Problems					
Bed Wetting					
Infertility					
Sciatica					
Fibromyalgia					
Poor Posture					
Sleep Problems					
Stroke					
Cancer					
Heart Disease					
Diabetes					
Arthritis					
Alzheimer's					

Informed Consent for Chiropractic Care

Chiropractic care, like all forms of health care, while offering considerable benefits may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases, injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include: sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care occurring at a rate between one instance per one million to one per to million cervical spine (neck) adjustments may be a vertebral injury that could lead to a stroke.

Prior to receiving chiropractic care in the chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific conditions, your overall health and in particular your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

I understand and accept that there are risks associated with chiropractic care and give consent to the examination that the doctor deems necessary and the chiropractic care, including spinal adjustments, as reported following my assessment.

I authorize and request payment of insurance benefits directly to Dr. Patrick McDonnell, D.C. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the practice member. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

Print name: _____

Signature: _____ Date: _____

If This Health Profile is for a Minor/Child, Please Fill Out and Sign Below Written Consent for a Child

Name of Practice Member who is a minor/child: _____

I authorize Dr. Patrick McDonnell D.C. and all Proper Chiropractic staff to perform diagnostic procedures, radiographic evaluations, render chiropractic care, and perform chiropractic adjustments to my minor/child. As of this date, I have the legal right to select and authorize health care services for my minor/child. If my authority to select and authorize care is revoked or altered, I will immediately notify Proper Chiropractic.

Guardian signature: _____ Date: _____

Relationship to minor/child: _____

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

1. Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physicians' certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

Signature: _____ Date: _____

X-Ray Authorization

(No earlier than 6 weeks postpartum)

As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files. At your request, we will provide you with a copy of your x-rays in our files. There is no fee to copy your x-rays on to a CD. Digital x-rays on a CD will be available within 72 hours of request on any regular practice hoursday. Please note: x-rays are utilized in this office to help locate and analyze vertebral subluxations. The Doctor of Proper Chiropractic does not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice.

By signing below, you are agreeing to the above terms and conditions.

Print name: _____ Date of Birth: _____

Signature: _____ Date: _____

FEMALES ONLY: To the best of my knowledge, I BELIEVE I AM NOT PREGNANT at the time the x-rays are taken at Proper Chiropractic.

Signature: _____ Date: _____