FOUNDATION
CHIROPRACTIC

PRENATAL NEW PATIENT INTAKE FORM

Full Name: _____ Preferred Name: _____
Date of Birth: _____/_____/_____ Marital Status/Spouse Name: _____
Address: _____
Phone: _____ Email: _____
Emergency Contact & Phone: _____
Occupation: _____ Type of Work: _____
# of Children: _____ Who can we thank for referring you? _____

CURRENT CONCERN (or write "Wellness" if none)

What brings you to the office today?

_____

When did it start? _____
How did it start? _____
How often does it occur? _____
Rate intensity (0=None – 10=Extreme): _____
Describe how it feels (sharp, dull, throbbing, etc.):

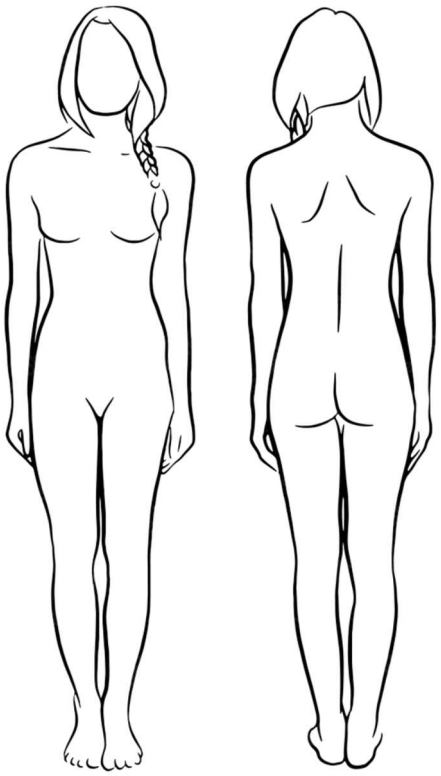
_____

What makes it better? _____
What makes it worse? _____
Is it: [ ] Getting Better [ ] Getting Worse [ ] Staying Same
Time of day it's the most painful: _____
Have you seen any other providers or had treatment for this? _____

What parts of your life/work/activities are most affected by this problem?

_____

Draw an "X" where you feel the issue. Use arrows to show if the pain moves or radiates.



PREGNANCY INFORMATION

Estimated Due Date: _____
OB/Midwife Name: _____ Provider Location: _____

This is pregnancy # _____ # of full-term births: _____ Miscarriages/other: _____
Planned Birth Location: _____

Planned Birth Method: ( ) Vaginal ( ) C-section ( ) VBAC
Any complications so far in this pregnancy? ( ) Yes ( ) No
If yes, please explain: _____

Have you experienced any of the following this pregnancy? (check all that apply)

( ) Sciatica	( ) Pubic Pain	( ) Low Back Pain	( ) Anxiety or Mood Changes
( ) Fatigue	( ) Sleep Issues	( ) Digestive Issues	( ) Round Ligament Pain
( ) Swelling	( ) Headaches	( ) Breech Presentation	

HEALTH HISTORY

List any major health concerns, surgeries, or traumas (past or present)

_____

Previous chiropractic care? ( ) Yes ( ) No If yes, when and why? _____

Have you had chiropractic care during a previous pregnancy? ( ) Yes ( ) No

If yes, did you find it helpful? _____

Current supplements/medications (including prenatal vitamins):

_____

Patient's Signature: _____ Date: _____

ChiroFutures

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 and treatment 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 spinal and extremity joint subluxations. **Vertebral subluxation** is a disturbance to 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.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, radiological examination (x-rays), and laboratory testing.

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. In addition, physiotherapy or rehabilitative procedures may be included in the management protocol. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

In addition to the benefits of chiropractic care and treatment, 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. Risks associated with physiotherapy may include the preceding as well as allergic reaction and muscle and/or joint pain. 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

Initials:

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 PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE FOUNDATION CHIROPRACTIC TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.
DATED THIS ___ DAY OF _____, 20__

_____ _____
Patient Signature **Doctor's Signature**

Parental Consent for Minor Patient:

Patient Name: _____

Patient age: _____ DOB: _____

Printed name of person legally authorized to sign for:

Patient: _____

Signature: _____

Relationship to Patient: _____

In addition, by signing below, I give permission for the above named minor patient to be managed by the doctor even when I am not present to observe such care.

Printed name of person legally authorized to sign for:

Patient: _____

Signature: _____

Relationship to Patient: _____

Remarks:

FOUNDATION
CHIROPRACTIC

907 Honea Egypt Road, Magnolia, TX 77354
832-458-3004

HEALTH CARE AUTHORIZATION FORM

I have been provided with a copy of the Notice of Privacy Practices for Protected Health Information. The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information (PHI) that will occur in my treatment, payment of my bills or in the performance of health care operations of this chiropractic office. A copy of our notice is attached, and we encourage you to read it and request your own copy if you would like one.

This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information. I hereby give permission to Foundation Chiropractic to use and/or disclose Protected Health Information in accordance with the following:

SPECIFIC AUTHORIZATIONS:

- I give permission to Foundation Chiropractic to use my email address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, newsletters, information about treatment alternatives or other health related information.

- If Foundation Chiropractic contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.

- I give permission to Foundation Chiropractic to use my name on a welcome board, referral board, and birthday board.

- I give permission to Foundation Chiropractic to use my photograph on their patient picture bulletin board and other marketing materials such as their brochure, website, and ads in print media.

- I give permission to Foundation Chiropractic to use any testimonial written by me for marketing purposes such as, sharing with other patients or potential patients, in their brochure, on their website or in ads in print media.

- I give Foundation Chiropractic permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with doctor at any time in private, the doctor will provide a room for these conversations.

- By signing this form, you are giving Foundation Chiropractic permission to use and disclose your protected health information in accordance with the directives listed above.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. This authorization will remain in effect for the duration of my care at Foundation Chiropractic plus 7 years or until revoked by me.

Initials:

RIGHT TO REVOKE AUTHORIZATION:

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of Foundation Chiropractic (Dr. Evan Pulver).
The written notice must contain the following information:

- Your name
- Date of birth
- A clear statement of your intent to revoke this AUTHORIZATION
- The date of your request
- Your signature

The revocation is not effective until it is received by the Privacy Official.

This AUTHORIZATION is requested by Foundation Chiropractic for its own use/disclosure of PHI. (Minimum necessary standards apply.)

I have the right to refuse to sign this AUTHORIZATION. If I refuse to sign this AUTHORIZATION,

Foundation Chiropractic will not refuse to provide treatment however, it will not be possible for Foundation Chiropractic to respond to third party billing on my behalf and I will be responsible for 1) scheduling my own appointments since Foundation Chiropractic will be unable to contact me 2) all contact with Foundation Chiropractic regarding my care. Additionally, any collection activity as permitted by law is not waived by refusal to sign the authorization.

I have the right to inspect or copy, within boundaries, the protected health information to be used/disclosed. A reasonable fee for copying will apply. A copy of the signed authorization will be provided to me.

HEALTHCARE AUTHORIZATION

I have read and understand this Healthcare Authorization Form and acknowledge receipt of The Notice of Privacy Practices for Protected Health Information. My signature below represents agreement with these practices.

Date of Birth: _____

Patient's Name (please print): _____

Patient's Signature: _____

Today's Date: _____

Name of Personal Representative (if someone is designated to act on your behalf/or for a minor):

Parent or Personal Representative name (please print):

Signature:

Description of Representative's Authority to Act on Patient's Behalf:

_____