PREGNANCY HEALTH ASSESSMENT

ChiropracticAlways Water Oak Suites, 123 East Main Street, 202-B, Brevard, NC 28712
(828)884-5557
drnewton@chiropracticalways.com

Today's Date: _____ Can we thank someone for referring you?_____

PERSONAL INFORMATION

Name:_____ Age:_____ Date of Birth: _____
Address: _____ City:_____State/Zip: _____
Home phone: (___) _____ Business Phone: (___) _____Cell Phone: (____) _____
SS#: _____ E-mail address:_____
Employer: _____ Occupation: _____
Marital Status: □ S □ M □ D □ W □ L/W Spouse/Partner's name: _____
Ages of Children: _____
Primary Doctor(s) : _____

We work closely with our patients to address their individual needs, Since everyone is different, we start by asking these questions to help us learn about you. These questions cover many of the physical, emotional and chemical stresses that can overwhelm your body over time and contribute to health problems and reduced vitality. We'll review it together during your appointment and use your answers to develop a clear picture of your health and wellbeing.

CURRENT HEALTH CONCERN:_____

If there are no current concerns and this assessment is to ensure optimum health, function and wellness check here _____

People seek chiropractic care for a number of reasons and have certain expectations and perceptions. Please tick the goals which apply to you so we can accommodate your wishes.
Improved quality of life __Pain Reduction___ Manage a Crisis ___ Stress reduction _____
Improvement in function____ Information on prevention ____Improved performance _Wellness ___
Symptom management ___Healthier immune system ____Keep me moving___Full body Integration_____
Optimum function and quality of life__ Longevity___ Other_____

ABOUT YOUR PREGNANCY

Is this your first pregnancy? Yes / No
If this is not your first, how many times have you been pregnant? _____
Have you had any complications with previous pregnancies? No/ Yes (please explain)_____
Miscarriage(s) No / Yes Months into your pregnancy:_____
Was this pregnancy planned? Yes / No What is the estimated date of delivery? _____
Who is your primary care giver for delivery? ObGyn/GP/Midwife?
Name:_____ Contact info: _____
What is your planned location for delivery? Hospital/ Home/ Birthing clinic/other _____
Do you have any concerns about this pregnancy?_____
Do you have a birth plan? Yes / No
Would you like information on creating a Birth Plan? Yes / No
Special arrangements for the birth? (planned C-sec, water delivery, birth chair, squat, other)
Would you like additional information on options for birth posturing? Yes / No
Circle any tests you've had: Genetic, blood, ultrasound, amniocentesis, chorionic villi sampling, other?
Dates and reasons:_____
Are you planning on breastfeeding? Yes / No
Would you like further information on the advantages of breastfeeding? Yes / No

PREGNANCY HEALTH ASSESSMENT

ChiropracticAlways Water Oak Suites, 123 East Main Street, 202-B, Brevard, NC 28712
drnewton@chiropracticalways.com

Was your blood pressure prior to pregnancy within normal range, low or high?
What is your present blood pressure and when was it last checked?
Have you changed your diet/menu since you became pregnant? Yes / No
Would you like additional information on healthy nutrition for pregnancy? Yes / No
Have you smoked prior to or during this pregnancy? Yes / No / Quit
Have you consumed alcohol during this pregnancy? Yes / No

ANY SYMPTOMS? PAIN 1-10 dull, sharp, burns, tingles, throbs, spasms

Swelling in the arms or legs? No / Yes
Low back pain? No / Yes How often? _____
Upper back pain? No / Yes How often? _____
Neck pain? No / Yes How often? _____
Rib or chest pain? No / Yes How often? _____
Any foot pains? No/ Yes How often? _____
Digestive complaints? Heart burn, constipation? No/ Yes How often? _____
Nausea or vomiting? No / Yes Frequency and when? _____
Arm or hand numbness/tingling? No / Yes How often? _____
Headaches? No/ Yes How often? _____
Pain radiating down the leg(s)? No / Yes How often? _____
Heart palpitations? No / Yes How often? _____
Dizziness or lightheadedness? No / Yes Start Date: _____
What happened? _____
What relieves? _____ What aggravates? _____
Does it radiate or cause problems elsewhere? _____
Any associated or related concerns? _____
Professionals seen for this? (name) _____
Treatment and results_____

OTHER HEALTH HISTORY

Present and/or past (please circle all that apply to you or family members: parents, siblings, parent of your children and/or or children)

Allergies, Stuffy nose, Runny sinuses, Frequent colds, Lowered resistance, Loss of balance , Difficulty concentrating, Dementia, Fatigue, Indigestion, Bloating, Appendicitis, Asthma, Bronchitis, Emphysema, Pneumonia, Bleeding disorders, Cancer , Cataracts, Vision changes, Diabetes, Hypoglycemia, Epilepsy, Heart Disease, Hypertension, Migraines, Hepatitis, High cholesterol, Difficulty with digestion, Loose stools , Hernia, Herniated Disc, Kidney Disease, Liver disease, Multiple Sclerosis, Osteoarthritis, Rheumatoid arthritis, Stroke, Osteoporosis, Parkinson's Disease, Thyroid problem, Tonsillitis, Ulcers, Urinary tract infections, Ulcerative colitis Other (list):

PREGNANCY HEALTH ASSESSMENT

ChiropracticAlways Water Oak Suites, 123 East Main Street, 202-B, Brevard, NC 28712
drnewton@chiropracticalways.com

PHYSICAL STRESSES

Any significant injuries, falls or traumas during infancy or childhood? Unsure//No/Yes (if yes please explain) _____
Any significant injuries, falls or traumas (car accidents) during adulthood? Unsure/No/Yes (if yes please explain) _____
Any hospital visits? No/Yes (if yes please explain) _____
Have you had any surgeries, fractures? No/Yes Explain + dates _____
Are you in prolonged postures (ex: repetitive work, lifting, sitting, driving) Unsure/No/Yes (if yes, please explain) _____
Any hobbies that are physically strenuous or have repetitive movements? Unsure/No/Yes (if yes, please explain) _____
What is your usual exercise routine? _____
Any fractured bones or dislocations? _____
Any vehicle accidents? No/Yes What happened and when? _____

CHEMICAL STRESSES

Are you taking prescription or over-the-counter medications? Yes / No (If yes, please list what and why) _____
Are you currently taking supplements? No / Yes
Which supplements and why?_____
Do you drink bottled water? Yes / No / Occasionally
Are you exposed to pollutants, strong smells, chemicals, aerosols? Yes / No / Occasionally
Do you eat organic foods? Yes / No / Occasionally
Do you use natural or environmentally friendly products in your home? I.E. Cleaning supplies, hair and makeup, etc. Yes / No
Do you drink, bathe or shower in chlorinated water? Yes / No

MENTAL/EMOTIONAL STRESSES

Psychological stress has been shown to affect numerous systems and fetal function.
Please rank the following with 1 being easy to 10 being difficult
Life in general ___ Work and Career Relationships Finances _____
Time management_____ Health & wellbeing__ Sports & hobbies_____
Quality of sleep _____About my pregnancy _____
If you are experiencing significant or ongoing stress please explain _____
_____
Do you practice some form of meditation, breath work, other mind-body movement or have a routine to reduce your stress? Yes /No Explain _____
Are you interested in learning about stress reduction practices? Yes / No

PREGNANCY HEALTH ASSESSMENT

ChiropracticAlways Water Oak Suites, 123 East Main Street, 202-B, Brevard, NC 28712
drnewton@chiropracticalways.com

PAYMENTS and INSURANCE VERIFICATION

Insurance is a contract between the insured, the patient, and the insurance company. The following information will help you to understand how insurance can be utilized in our office and the details regarding your participation in the process.

Please have the following information when calling your insurance company:

1. Insurance company's phone number (on the back of your card): _____
2. Policy holders name (if different from patient): _____

Please obtain and verify the following information. They cannot process your claim without this information.

1. Ask for the name of the person giving you this information: _____
2. Ask if you have chiropractic coverage for out of network providers. If yes, please continue to verify type and amount of coverage. _____
3. What is the yearly deductible: _____ Per Person: _____ Per Family: _____
4. How much of the deductible has been met this year? _____
5. What is the co-pay: _____
6. Is there a limit to the number of visits or a $ amount? _____ If yes, how many visits are allowed and/or what is the $ limit? _____
7. Are services limited by Medical Necessity? _____
8. Does your plan cover Wellness or Maintenance Care? _____
9. What is the effective date of the policy? _____
10. Policy holder's employer: _____ ID# _____ Group # (if applicable): _____

a. **Name and address of the insurance office where the claims are sent:**

_____

_____

_____

Thank you for obtaining and verifying this information with your insurance company. Your coverage will determine how they reimburse you.

SUBMITTING BILLS TO YOUR INSURANCE COMPANY

If you determine that your insurance plan will reimburse you for chiropractic care in our office, we will provide you with itemized monthly statements for you to submit. Please indicate below the type of statement you may need.

☐ Flex Plan or Health Savings Account Statement

☐ Insurance Statement

PREGNANCY HEALTH ASSESSMENT

ChiropracticAlways Water Oak Suites, 123 East Main Street, 202-B, Brevard, NC 28712
drnewton@chiropracticalways.com

INSURANCE PROCEDURES:

Insurance companies, such as HMO's, PPO's and others, create their own guidelines and are not required to cover chiropractic services. If chiropractic services are covered, the amount and type of reimbursement varies according to the policy that has been purchased by you or your employer. (See reverse for details)

If you have determined that your insurance will cover your care in our office, we will supply you with all of the paperwork necessary for you to get reimbursed quickly. We will give you a statement at the end of your first week and then once a month after that. When you send in your statements, your insurance company will reimburse you directly. They are responsible to you, as the subscriber, not to us, the provider.

AUTO ACCIDENTS AND WORK-RELATED INJURIES:

If your insurance company requires direct billing from us, we will supply the necessary information for them to remit payment to our office on your behalf. Please understand that you are responsible to pay for all services until we receive approval and/or payment from the insurance carrier. Once payment is verified you will be reimbursed accordingly. You are still responsible for deductibles, co-payments, and any other balances not reimbursed by the insurer.

NOTE: You must verify the type and amount of coverage before we can submit claims on your behalf. Until we receive this information and verification and/or payment from the insurance company, your account will be on a cash basis.

I have read, understand and agree to complete all forms necessary to allow ChiropracticAlways to assist me with insurance reimbursement. I understand that I am personally responsible for all services received should my insurance fail to remit payment. I agree to pay for all services I receive here on the date they are provided.

Date:_____

Patient Name _____

Patient Address: _____

Patient Signature:_____

Guardian/Spouse/Parent Name_____ Signature:_____

PREGNANCY HEALTH ASSESSMENT

ChiropracticAlways Water Oak Suites, 123 East Main Street, 202-B, Brevard, NC 28712
drnewton@chiropracticalways.com

CONSENT FORM

- A copy of ChiropracticAlways' "Notice of Privacy Practices for Protected Health Information (HIPAA)" brochure is available for my review both in the office and on www.chiropracticalways.com website.
- I consent to receive communication from ChiropracticAlways in connection with my care via email, postal mail, text and telephone messaging. If I should withdraw my consent, I will notify the office in writing.
- I consent to my photo or image being used in photograph or video in public media including social media, website, promotional materials. If I should withdraw my consent, I will notify the office in writing.
- It has been explained verbally and in writing that Chiropractic can sometimes have side effects or risk of ataxia, bruising, thermal injury, dislocation/subluxation, dizziness, "drop attacks", fracture, mobility disruption, paralysis, quadriplegia, spinal injury, stroke/disruption of blood flow to the brain, visual disturbances, pain, tinnitus, hallucination or death. While none of these complications have ever occurred under my care, should this happen in your case, for your protection, you would be referred immediately to another physician or appropriate health care provider for surgery or other "standards of care" treatment.
- On rare occasions side effects of massage can include bruising, inflammation, swelling and pain.
- I acknowledge that the risks of Chiropractic treatment have been explained to me verbally and in writing, I assume full responsibility for these risks.
- Should I choose detoxification as a treatment with Dr. Newton, I recognize that as my body releases poisons, there may be associated memory which comes to the surface (somatic-visceral) and I agree to obtain professional council upon the recommendation of Dr. Newton.
- I understand that detoxification can sometimes have side effects or risk of nausea, vomiting, diarrhea, memory recall and fainting.
- I fully understand the above Consent Form Information. I fully understand the risks and limitations of Chiropractic Care, Massage and Detoxification. I understand and fully consent to treatment with Dr. Newton for Chiropractic, Massage and Detoxification when it has been determined the care is needed. No guarantee of assurance of results has been made. I agree and intend this consent form to cover the procedures recommended in my case including the use of Chiropractic Care, Evaluation, Diagnosis, Adjustments, massage, Detoxification Methods, Manipulations, and treatment for any future conditions for which I seek treatment.

Date:_____

Patient Name_____

Patient Address:_____

Patient Signature:_____

Guardian/Spouse/Parent Name_____Signature:_____

Witness: _____

Welcome to ChiropracticAlways!