Edgewood Chiropractic Center
1114 W Cook Road Fort Wayne, IN 46825
(260) 483-5588

PRENATAL Chiropractic Case History/Patient Information

Office use:
Date:_____ Patient # _____ Doctor:_____

NAME: _____ SOCIAL SECURITY #_____-_____-_____
HOME PHONE:__(_____)_____-_____ CELL PHONE:__(_____)_____-_____
ADDRESS:_____CITY:_____ STATE:_____ ZIP:_____
E-MAIL ADDRESS:_____@_____
AGE:_____ BIRTHDATE:_____ MARITAL STATUS: M S W D
OCCUPATION: _____ EMPLOYER:_____
EMPLOYER'S ADDRESS:_____ WORK PHONE: (____)_____-_____
SPOUSE'S NAME:_____OCCUPATION:_____ EMPLOYER:_____
HOW WERE YOU REFERRED TO OUR OFFICE:_____
FAMILY MEDICAL DOCTOR:_____When was your last physical examination?_____

History of Present Illness:

CHIEF COMPLAINT (Purpose of this appointment):
_____
DATE OF ONSET OR ACCIDENT: _____ DAYS LOST FROM WORK: _____
IS THIS DUE TO: ≤ AUTO ≤ WORK ≤ OTHER:_____
Is this a recurrence? ≤ YES ≤ NO If so, when did you first notice the problem?
_____
How long does it last? ≤ ALL DAY ≤ FEW HOURS_____ ≤ MINUTES_____
How frequent is the condition? ≤ CONSTANT ≤ DAILY ≤ INTERMITTENT ≤ NIGHT ONLY
DESCRIBE the pain: ≤ SHARP ≤ DULL ≤ NUMBNESS ≤ TINGLING ≤ ACHING ≤ BURNING ≤ STABBING
≤ OTHER:_____
Is there anything you can do to relieve the problem? ≤ YES ≤ NO If yes, explain:_____
What makes the problem worse? ≤ STANDING ≤ SITTING ≤ LYING DOWN ≤ BENDING ≤ LIFTING ≤ COUGHING ≤ TWISTING ≤
OTHER:_____
PAIN INTENSITY: Please put line on scale describing the intensity of your pain

Have you ever had chiropractic care before? YES NO
DUE DATE: _____
Is this your 1st pregnancy? YES NO
If no, how many pregnancies? _____
How long did it take you to conceive? _____
Did you have any fertility issues? YES NO If YES, explain _____
Oral contraception use? YES NO If YES, how long? _____
Have you had any miscarriages? YES NO If YES, how many? _____
Previous birth experience (circle): VAGINAL FORCEPS VACUUM INDUCED C-SECTION VBAC
Medications/Drugs during labor: YES NO If YES, please list: _____
Prenatal vitamins? YES NO IF YES, which brand? _____

Patient Signature:_____ Date:_____
Doctor's Signature:_____ Date:_____

Patient Name:_____ Patient No:_____

Medical History:

Please check all that apply:

DISEASE/CONDITION	YES	NO	RELATIONSHIP TO YOU
Alcoholism	≤	≤	
Arthritis	≤	≤	
Asthma	≤	≤	
Broken/Fractured Bones	≤	≤	
Cancer	≤	≤	
Circulatory Problems	≤	≤	
Coughing Blood	≤	≤	
Depression	≤	≤	
Diabetes	≤	≤	
Drug Addiction	≤	≤	
Epilepsy	≤	≤	
Excessive Bleeding	≤	≤	
Heart Disease	≤	≤	
High/Low Blood Pressure	≤	≤	
Kidney Disease	≤	≤	
Liver Disease	≤	≤	
Lung Disease	≤	≤	
Mental Illness	≤	≤	
Osteoarthritis	≤	≤	
Back Pain	≤	≤	
Neck Pain	≤	≤	
Seizures/Convulsions	≤	≤	
Stroke/Hypertension	≤	≤	
Ulcers	≤	≤	
Other:			
Other:			

HOSPITALIZATIONS (Please list surgeries, including childbirth): _____

Have you had any major illnesses, injuries, falls or auto accidents?_____

Have you been treated for any health condition by a physician in the last year? ≤ YES ≤ NO

If yes, describe:_____

Please list any CURRENT MEDICATIONS_____

Social History:

Do you take vitamin supplements? ≤ YES ≤ NO If so, please list:_____

Do you consume caffeine? ≤ YES ≤ NO If so, how much per day?_____

Do you exercise? ≤ YES ≤ NO If yes, what is the frequency and type of exercise?_____ What are your

hobbies?_____

What percentage of time during the day (at home or at your workplace) do you spend:

Lifting? _____ Sitting? _____ Bending? _____ Working at a computer? _____

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HIPAA Privacy Notice

Edgewood Chiropractic Center strives to maintain the strictest confidentiality of your medical and financial information. Our employees are all aware that this information belongs to you and you have the right to decide how it is used in most instances. At this time you may request to view or receive a copy of our HIPAA policy.

To better serve you, we need you to sign and date this form acknowledging that you have read this notice and that an opportunity to review or receive a copy of our HIPAA policy has been made available to you upon request.

Financial Policy

It is the policy of this office that all services rendered are charged directly to you, the patient, and that ultimately the patient is responsible for all services, including those not reimbursed by third party payers. All payments are due at the time of service, unless prior arrangements have been made.

Our office accepts assignment with most insurance companies, however **insurance is not a guarantee of payment**. Your insurance is an agreement between you and your insurance company. All insurance assignment patients must pay their deductibles in full and copayment/coinsurance at time of service. If our office has not received payment by your insurance company within forty five (45) days of our office filing the claim, you will become responsible for payment in full.

I, the undersigned, do hereby agree to be financially responsible for the entire balance due, including, but not limited to, the examination, consultation, and/or treatment. I also agree to pay a service charge of $35.00 if my check is returned for insufficient funds. I understand that this service charge may be in addition to any fees assessed by my financial institution. Furthermore, I agree that a late charge of 1.5% per month may be assessed on delinquent balances. In the event of any default in payment, I agree to pay all attorney fees and/or other collection costs necessary to collect on my account.

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures: physical examination, tests, physio therapy, physical medicine, physical therapy procedures, etc. on me by the doctor of chiropractic at Edgewood Chiropractic Center and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon 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, that are in my best interest.

I have read (or have had read to me) the above explanation of the chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future conditions(s) for which I seek treatment.

SIGN AFTER YOU AGREE TO THE ABOVE

_____
Printed name of Patient

x_____ _____
Signature of Patient Date

x_____ _____
Signature of Representative (if patient is a minor or POA) Date

x_____ _____

Witness to Patient's Signature Date

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Pain Chart

Patient's Name:_____

Please make a slash through this line to indicate the level of your pain.

No Pain **Worst Pain Possible**

Draw location and type of pain on the body outline.

Pain Representation

Ache:
v v v v v v v v

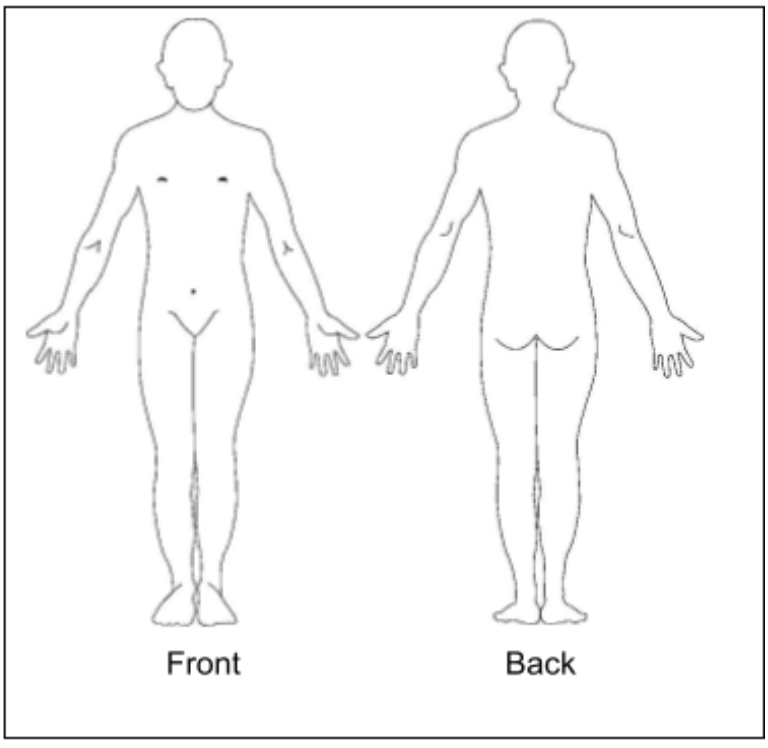
Burning:
= = = = = = = =

Numbness:
O O O O O O O

Pins & Needles:

Stabbing:
/ / / / / / / / /

Other:
x x x x x x x



Patient’s Signature Date