DELONG FAMILY CHIROPRACTIC

**CONGRATULATIONS!!**
*on your*
**PREGNANCY**

Full Name: ______________________________ DOB: ______________ Age: __________

Address: ____________________City:_______________State:__________Zip:__________

Phone Number: ______________________________ Email: ______________________________

Marital Status: Single / Married / Widowed (circle one)

Emergency Contact: ________________________________________________________

Emergency Contact Phone Number: ____________________ Relation: ____________________

Whom may we thank for referring you? ________________________________________

---

Week of Pregnancy __________ Due Date ________ Sex of baby: Male / Female / Unknown

Name of OB/Midwife: ______________________ Name of the Practice: ______________________

May we contact them? YES / NO (circle one)

Name of Doula: _______________________ Name of the practice: _________________________

May we contact them? YES / NO (circle one)

Is this your first Pregnancy? Yes / No If no, how many times have you been pregnant? _________

Name and ages of current children: ________________________________________________

If you have had miscarriage(s), how far along in the pregnancy did it occur? ________________

Was this pregnancy planned? Yes / No

What is your planned location to deliver? Home / Birthing Center / Hospital / Other: ___________

Do you have a birth plan? Yes / No Would you like information on creating one? Yes / No

Any special arrangements for the birth? (VBAC, planned c-section, induced, water delivery, birth chair, squat, other) ______________________________________________________

Are you planning to breastfeed? Yes / No Would you like more info? Yes / No

Are you taking pre-natal or birthing classes? Yes / No If yes, please explain: _______________

________________________________________________________________________

---

Did you have difficulty conceiving? Yes / No If yes, please explain: _______________________

________________________________________________________________________

Have you ever used any form of hormonal or oral contraceptives? Yes / No

If yes, which ones, and for how long? ______________________________________________

Have you experienced morning sickness? Yes / No If yes, please explain: ______________________

______________________________________________________________________________

Do you have concerns from a previous pregnancy, labor, birth or postpartum period that you would like to address during this pregnancy? ______________________________________________________

Are you currently taking any medications or supplements (please list)? ___________________________

______________________________________________________________________________

Have you been vaccinated during pregnancy? ______________________________________________

What do you intend to do for vaccines for your baby at birth? _________________________________

What is your sleep quality (circle one)? Good/ Fair/ poor How many hours per night? __________

What was your pre-pregnancy weight? ___________________ Current weight? ____________________

Do you exercise currently? Yes / No What type / how often? _________________________________

Current diet and any dietary restrictions. ____________________________________________________

---

**Your top three goals for this pregnancy:**

1. ______________________________________________________________________
2. ______________________________________________________________________
3. ______________________________________________________________________

**People seek chiropractic care for several reasons and have certain expectations and perceptions. Please check the goals which apply to you, so we can accommodate your wishes.**

- ☐ Improvement in function
- ☐ Pain reduction
- ☐ Relief
- ☐ Improved quality of life
- ☐ Manage my crisis
- ☐ Information on prevention
- ☐ Symptom management
- ☐ Healthier immune system
- ☐ Stress reduction
- ☐ Keep me moving
- ☐ Optimum function
- ☐ Improved performance
- ☐ Full body integration
- ☐ Wellness
- ☐ Longevity
- ☐ Other: ____________________

**Since psychological stress has been shown to affect numerous systems and fetal function, please let us know how you are coping with life's stresses. Rank from 1 to 10 with 1 being minimal to 10 being extreme)**

Life in general ______
Financial stress ______
Health and well-being ______
Work and Career ______
Time management ______
About my pregnancy ______
Relationships ______
Sports & hobbies ______
Quality of sleep ______

If you are experiencing significant or ongoing stress, please explain ______________________________

Do you practice or have some form of routine to reduce your stress? Yes / No

If yes, please explain: ______________________________________________________________

**Please identify the condition(s) that brought you to this office and on a scale of 1 to 10 with 10 being the worst possible pain and 0 being no pain, rate your conditions:**

Primary: ______________________________ 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Secondary: ____________________________ 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Third: _________________________________ 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Have you experienced any of the above conditions before the start of your pregnancy? Yes / No

If yes, please explain: ______________________________________________________________

**Please check if any of these pertain to you:**

- ☐ Over the age of 36
- ☐ First Pregnancy
- ☐ Pregnant with Multiples
- ☐ Morning sickness, vomiting, nausea
- ☐ Gestational Diabetes
- ☐ High Blood Pressure
- ☐ Placental Dysfunction
- ☐ Swollen feet and/or hands
- ☐ Phlebitis
- ☐ Varicose Veins
- ☐ Pubic Pain
- ☐ Low back pain
- ☐ Bed rest
- ☐ Heartburn
- ☐ Indigestion
- ☐ Constipation
- ☐ Breech/Transverse
- ☐ Leg Cramps/Restless legs
- ☐ Difficulty sleeping
- ☐ Bladder or kidney infection
- ☐ Pre-eclampsia
- ☐ Premature labor
- ☐ Threatened Miscarriage
- ☐ Sciatic Pain
- ☐ Neck Pain
- ☐ High risk
- ☐ Headache
- ☐ Other: ________________________

---

Have you suffered with any of this or a similar problem in the past? Yes / No

If yes, how many times? ________________ When was the last episode? ________________

Other forms of treatment tried? Yes / No If yes, what treatment: ___________________________

Who provided it? ________________ How long? ____________ Results: Favorable / Unfavorable

**Have you ever been diagnosed with any of the following conditions in the past?**

- ☐ Broken bone
- ☐ Dislocation
- ☐ Heart attack
- ☐ Osteo Arthritis
- ☐ Tumors
- ☐ Diabetes
- ☐ Rheumatoid Arthritis
- ☐ Cerebral Vascular
- ☐ Disability
- ☐ Cancer
- ☐ Other: ________________

Please identify all past injuries, surgeries, childhood illnesses, and adult illnesses (how long ago & type of care received): ______________________________________________________________

Do you smoke? Yes / No If yes, how often: daily / weekends / occasionally

Do you drink alcohol? Yes / No If yes, how often: daily / weekends / occasionally

Do you use recreational drugs? Yes / No If yes, how often: daily / weekends / occasionally

**Please identify how your current condition is affecting your ability to carry out activities of daily living:**

| | | | | |
|---|---|---|---|---|
| Bending | ☐ No Effect | ☐ Painful (can do) | ☐Painful (Limits) | ☐ Unable to Perform |
| Concentrating | ☐ No Effect | ☐ Painful (can do) | ☐Painful (Limits) | ☐ Unable to Perform |
| Doing computer Work | ☐ No Effect | ☐ Painful (can do) | ☐Painful (Limits) | ☐ Unable to Perform |
| Gardening | ☐ No Effect | ☐ Painful (can do) | ☐Painful (Limits) | ☐ Unable to Perform |
| Playing Sports | ☐ No Effect | ☐ Painful (can do) | ☐Painful (Limits) | ☐ Unable to Perform |
| Recreation Activities | ☐ No Effect | ☐ Painful (can do) | ☐Painful (Limits) | ☐ Unable to Perform |
| Sleeping | ☐ No Effect | ☐ Painful (can do) | ☐Painful (Limits) | ☐ Unable to Perform |
| Watching TV | ☐ No Effect | ☐ Painful (can do) | ☐Painful (Limits) | ☐ Unable to Perform |
| Carrying | ☐ No Effect | ☐ Painful (can do) | ☐Painful (Limits) | ☐ Unable to Perform |
| Dancing | ☐ No Effect | ☐ Painful (can do) | ☐Painful (Limits) | ☐ Unable to Perform |
| Dressing | ☐ No Effect | ☐ Painful (can do) | ☐Painful (Limits) | ☐ Unable to Perform |
| Lifting | ☐ No Effect | ☐ Painful (can do) | ☐Painful (Limits) | ☐ Unable to Perform |
| Pushing | ☐ No Effect | ☐ Painful (can do) | ☐Painful (Limits) | ☐ Unable to Perform |
| Rolling Over | ☐ No Effect | ☐ Painful (can do) | ☐Painful (Limits) | ☐ Unable to Perform |
| Sitting | ☐ No Effect | ☐ Painful (can do) | ☐Painful (Limits) | ☐ Unable to Perform |
| Standing | ☐ No Effect | ☐ Painful (can do) | ☐Painful (Limits) | ☐ Unable to Perform |
| Working | ☐ No Effect | ☐ Painful (can do) | ☐Painful (Limits) | ☐ Unable to Perform |
| Climbing | ☐ No Effect | ☐ Painful (can do) | ☐Painful (Limits) | ☐ Unable to Perform |
| Doing Chores | ☐ No Effect | ☐ Painful (can do) | ☐Painful (Limits) | ☐ Unable to Perform |
| Driving | ☐ No Effect | ☐ Painful (can do) | ☐Painful (Limits) | ☐ Unable to Perform |
| Performing Sexual Activity | ☐ No Effect | ☐ Painful (can do) | ☐Painful (Limits) | ☐ Unable to Perform |
| Running | ☐ No Effect | ☐ Painful (can do) | ☐Painful (Limits) | ☐ Unable to Perform |
| Sitting to Standing | ☐ No Effect | ☐ Painful (can do) | ☐Painful (Limits) | ☐ Unable to Perform |
| Walking | ☐ No Effect | ☐ Painful (can do) | ☐Painful (Limits) | ☐ Unable to Perform |

## QUADRUPLE VISUAL ANALOGUE SCALE

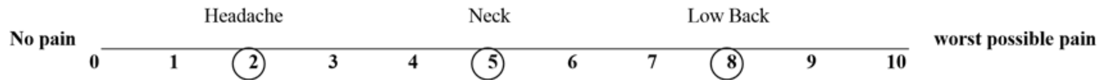
Patient Name ______________________________ Date ____________________

**Please read carefully:**

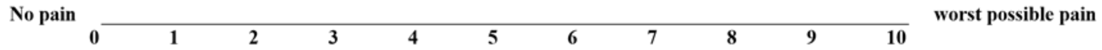
**Instructions:** Please circle the number that best describes the question being asked.

**Note:** If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

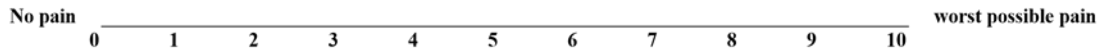
**Example:**



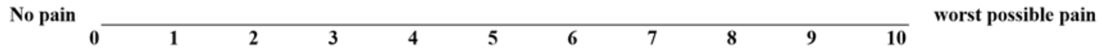

**1 – What is your pain RIGHT NOW?**



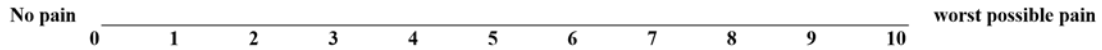

**2 – What is your TYPICAL or AVERAGE pain?**




**3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?**




**4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?**




**OTHER COMMENTS:**

______________________________________________________________

______________________________________________________________

______________________________

Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

# INFORMED CONSENT FOR TREATMENT

**REGARDING:** Chiropractic Adjustments, Modalities, X-rays, and Therapeutic Procedures:

To the best of my knowledge, this form is accurate and complete. I have disclosed all known health conditions and will inform Dr. Jill of any changes in my health status at the beginning of future appointments. I agree to discuss my pregnancy as it progresses, and I consent to treatment.

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to on per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and all other procedures provided at DeLong Family Chiropractic, have been explained to me to my satisfaction. I do hereby consent to treatment by any means, methods, and or techniques the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

Patient Signature: ________________________________________ Date: ______________________

Witness Signature: ________________________________________ Date: ______________________

**REGARDING:** X-Rays / Imaging Studies. *Please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions.*

- ☐ The first day of my last menstrual cycle was on _____ - _____ - _____ Date
- ☐ I have been provided a full explanation of when I am most likely to become pregnant and/or I am currently pregnant.

By signing below, I am acknowledging that the doctor and or member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

Patient Signature: ________________________________________ Date: ______________________

Witness Signature: ________________________________________ Date: ______________________

I hereby authorize payment to be made directly to DeLong Family Chiropractic, for all benefits which may be payable under a healthcare plan or from any other collateral source. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to DeLong Family Chiropractic for any and all services I receive at this office.

Patient Signature: ________________________________________ Date: ______________________

Witness Signature: ________________________________________ Date: ______________________

**Office Policies ~ Welcome to DeLong Family Chiropractic!**

As a potential new patient, we feel it is important that you understand our office policies regarding, how patients of this practice are cared for, and the various methods we offer to facilitate payment for that care. Please read each policy carefully so there is no misunderstanding as to what you can expect as a patient of this practice, and what we expect in return. Once you have read "Our Office Policies", if you have any questions or any of these policies are unclear to you, please let our front desk know and a member of our staff will be happy to discuss them with you further. We believe it is in everyone's best interests to provide potential new patients as much information as possible about how the doctors at this office practice chiropractic so that an informed decision can be made as to whether they wish to become a patient.

Over time, our patients gain a greater understanding as to the purpose of chiropractic. Since the majority of patient care occurs in an open bay area, patients have a unique opportunity to observe firsthand the positive results that are achieved.

☐ **PATIENT PRIVACY** – Since the majority of patient care takes place in an open bay area it is important to understand that any conversations you have with the doctor can be overheard by other patients. In order to maintain patient privacy, it is the policy of this practice to refrain from discussing any confidential matters with patients during treating hours while patients are being adjusted. If you have a confidential matter you wish to discuss, please let us know and we will schedule time for you to speak to the doctor in a private consultation room. These consultations must be scheduled in advance.

☐ **YOUR CARE** - When a patient seeks chiropractic health care and we agree to provide that care, it is essential for the patient and the doctor to be working toward the same objective. Chiropractic care at DeLong Family Chiropractic is rendered primarily to minimize and reduce subluxations, which are a major interference to the expression of the body's innate wisdom. The doctors use a myriad of techniques to accomplish this goal, including but not limited to Palmer Package. It is important that you understand both the objective and the method(s) so there is no confusion or disappointment. Your doctor will outline a course of treatment that will take you beyond simple pain relief, through two distinct phases of care to make a structural correction to your spine that will enable your central nervous system to function optimally, thereby improving you overall health.

☐ **FIRST THINGS FIRST**- Prior to receiving chiropractic care at this office, a health history and examination will be completed. Imaging studies as well as any other necessary diagnostics may also be ordered, to confirm the true nature of your condition and exact location of subluxations. The results of these procedures will aid in assessing your presenting problem, your overall health and the condition of your spine. They will also assist the doctor in determining the type and amount of care you will need. All relevant findings will be reported to you along with care plan recommendations so that you can make the best possible decision regarding your health care needs. Our gold standard for care is to ensure the reduction of subluxation while teaching patients what they need to do in addition to being adjusted to maintain their health for a lifetime.

☐ **PATIENT'S REPORT OF FINDINGS** – To enhance your understanding of the chiropractic approach that will be used to manage your health, immediately following your first adjustment, you will be scheduled for a 'Doctors Report of Findings'. The information you receive at this appointment will be both informative and clinically relevant to your case, therefore attendance is required for individuals who wish to become new patients of this practice. Because the results of your x-rays and all examinations as well as the doctors' recommendations for care will be discussed at that time, we strongly urge new patients to invite their spouse or significant other to attend.

______________________________________ _______________
Patient's Name DOB

______________________________________ _______________
Patient signature Date

______________________________________ _______________
Witness Date

## HIPPA Law #101-191 Consent Form

The information you provide us is kept in the strictest of confidence.
While protecting your privacy is extremely important to us, there may be certain situations in which we may have to use or disclose your health information.

1. It may be necessary to use or disclose your private health information to another health care provider or hospital, if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health issue.
2. It may be necessary to use or disclose your private health information and billing records to another party if they are responsible for the payment of your services.
3. It may be necessary to use or disclose your private health information within our practice for quality control and operational purpose including:
    - a. appointment reminders at home
    - b. appointment reminders at work
    - c. leaving messages on a voicemail or answering machine
    - d. testimonials of your improvement in written or verbal form
    - e. sending you marketing materials
    - f. information about alternative treatments
    - g. other health related information that may be of interest to you
    - h. "Thank you" correspondence

**Patients' Rights Under HIPPA Law #101-191**

1. You have the right to request that we do not disclose your private health information to specific individuals, companies, or organizations under the following circumstances:
    - a. all request must be in writing
    - b. by law we are not required to agree with your restrictions however, if we agree with your restrictions, the restriction is binding on us.
2. You have the right to REVOKE your authorization under certain conditions.
    - a. it must be in writing
    - b. the request will not be honored if we have already released your private health information before we received your request to revoke the authorization. If you were required to give authorization as a condition of obtaining insurance, the insurance may hat the right to our private health information, should they decide to contest any of your claims. Information that we use or disclose based on authorization you are giving us may be subject to re-disclosure by anyone that has access to the remainder of other information and may no longer be protected by the federal privacy rules.
    - c. If you do not give us authorization, it will not affect the treatment we provide to our patients or the methods we use to obtain reimbursement for services rendered to you.

I have read your consent policy and agree to its terms. I also acknowledge that once I sign this consent form I will receive a copy of this completed form for my own records. This notice is effective on the date below and will expire seven years after the date upon which the record was created.

| ______________________________ | ______________________________ | ________________ |
|---|---|---|
| Print your name | Signature | Date |

| ______________________________ | ________________ |
|---|---|
| Witness Signature | Date |

- Note: We have a more detailed notice of "Private Health Information" and you have the right to review the detailed notice before you sign this consent form. We have the right to change our privacy practices as described in the detailed notice. If any changes occur in reference to our privacy practices you will be notified by posting of the changes in the office or a notice will be sent to you in the mail. You may request a copy of our privacy notices at any time.