Whom may we thank for referring you to this office → ___________________________________

PREGNANCY APPLICATION FOR CARE AT NEW JOURNEY CHIROPRACTIC

Today's Date: __________________

Patient Information

Name: ____________________________________Birth Date: _____-_____-_____ Age: _______ ☐ Female ☐ Male

Address: _____________________________________ City: ______________________________ State: _____ Zip: ______

E-mail Address: _________________________________ Home Phone: __________________Mobile Phone:_____________

Marital Status: ☐ Single ☐ Married Do you have insurance: ☐ Yes ☐ No Work Phone: ___________________________

Employer: ____________________________________ Occupation: ____

Spouse's Name: _______________________________ Spouse's Date of Birth: _____-_____-_____

Number of children and Ages: ____

Have you had Previous Chiropractic Care ☐ No ☐ Yes

If Yes, what was the reason for visit? _______________________________________

Name of Previous Chiropractor: ____________________________

How long were you under care: ____________ What were the results? ____

Emergency Contact

Name ____ Relationship: ____

Phone Number_________________________________

Pregnancy Profile

How far along in your pregnancy are you? ______________ When is your baby's due date? ____-____-____

Have you taken any medication during this pregnancy? ☐ Yes ☐ No

Over The counter and Reason: ____

Prescription and Reason: ____

Vaccines and Reason: ____

Have you experienced any physical trauma during this pregnancy? ☐ Yes ☐ No Explain:_________________________________

Have you had any evaluation procedures (ultrasound, amniocentesis, chorionic villus sampling)? ☐Yes ☐No

Dates and Reasons: ____

Have there been any stressful events in your life during this pregnancy? ☐Yes ☐No Explain: ______________________________

____

What type of birth care provider are you planning on using? ☐ Midwife ☐ OB/Gyn ☐ Medical Doctor ☐ Other

Where do you plan on delivering? ____

Is this your first pregnancy? ☐ Yes ☐ No

If not how many pregnancies previously? ____

How many children do you have? ____

Miscarriages? ☐ Yes ☐ No ☐D&C ☐ Natural Miscarriage

How many vaginal deliveries? ____

How many caesarean sections? ____

Have there been any complications during your previous deliveries? ☐ Yes ☐ No ____________________________

Was labor induced/use of Pitocin? ☐ Yes ☐ No ☐ Unknown

Did your care provider rupture your membrane? ☐ Yes ☐ No

Was there any back or hip pain during pregnancy? ☐ Yes ☐ No

Was baby in a suboptimal position during the pushing phase of any labor? ☐ Yes ☐ No ☐ Unknown

Did you receive and epidural? ☐ Yes ☐ No

Were there any operative devices used? ☐ Yes ☐ No ☐ Forceps ☐ Vacuum

Any postpartum complications or long-term consequences? ☐ Yes ☐ No ____________________________________

Have you experienced any of the following symptoms during this pregnancy or a previous pregnancy?

***Please check C = Current /P = Past or/ N = Never**

C / P / N
☐ ☐ ☐ Headaches
☐ ☐ ☐ Facial Paralysis
☐ ☐ ☐ Chronic Fatigue
☐ ☐ ☐ Nausea/ Morning Sickness
☐ ☐ ☐ Heartburn/ Indigestion
☐ ☐ ☐ Preeclampsia
☐ ☐ ☐ Gestational Diabetes
☐ ☐ ☐ Constipation
☐ ☐ ☐ Hemorrhoids
☐ ☐ ☐ Carpal Tunnel
☐ ☐ ☐ Low/Midback pain
☐ ☐ ☐ Breech or Side lying Presentation
☐ ☐ ☐ Round ligament Pain/Pulling
☐ ☐ ☐ Pain in your pubic bone
☐ ☐ ☐ Pins/Needles in the Front/Side of your leg
☐ ☐ ☐ Pain in Posterior Leg
☐ ☐ ☐ Leg Cramps
☐ ☐ ☐ Swelling Ankles, Legs or Feet
☐ ☐ ☐ Neck Pain
☐ ☐ ☐ Jaw pain, TMJ
☐ ☐ ☐ Shoulder Pain

C / P / N
☐ ☐ ☐ Upper Back Pain
☐ ☐ ☐ Hip pain
☐ ☐ ☐ Back Curvature
☐ ☐ ☐ Scoliosis
☐ ☐ ☐ Frequent Colds/Flu
☐ ☐ ☐ Convulsions/Epilepsy
☐ ☐ ☐ Tremors
☐ ☐ ☐ Chest Pain
☐ ☐ ☐ Pain w/ Coughing sneezing
☐ ☐ ☐ Foot or Knee Problems
☐ ☐ ☐ Sinus/Drainage Problems
☐ ☐ ☐ Swollen/Painful Joints
☐ ☐ ☐ Skin Problems
☐ ☐ ☐ Dizziness
☐ ☐ ☐ Loss of Balance
☐ ☐ ☐ Fainting
☐ ☐ ☐ Double Vision
☐ ☐ ☐ Blurred Vision
☐ ☐ ☐ Ringing in Ears
☐ ☐ ☐ Hearing loss
☐ ☐ ☐ Depression
☐ ☐ ☐ Irritable
☐ ☐ ☐ Mood changes

C / P / N
☐ ☐ ☐ ADD/ADHD
☐ ☐ ☐ Allergies
☐ ☐ ☐ Incontinence
☐ ☐ ☐ Digestive Problems
☐ ☐ ☐Colon Trouble
☐ ☐ ☐ Diarrhea/Constipation
☐ ☐ ☐ Bed Wetting
☐ ☐ ☐ Learning Disability
☐ ☐ ☐ Eating Disorder
☐ ☐ ☐ Trouble Sleeping
☐ ☐ ☐ Ulcers
☐ ☐ ☐ Heart Problems
☐ ☐ ☐ High Blood Pressure
☐ ☐ ☐ Low Blood Pressure
☐ ☐ ☐ Asthma
☐ ☐ ☐ Difficulty Breathing
☐ ☐ ☐ Lung Problems
☐ ☐ ☐ Kidney Trouble
☐ ☐ ☐ Gallbladder Trouble
☐ ☐ ☐ Liver Trouble
☐ ☐ ☐ Hepatitis (A,B,C)

List of Prescription & Non-Prescription drugs you take:____
____
____

HISTORY OF COMPLAINT

Please identify the condition(s) that brought you to this office, and on a scale of 1 to 10 with 10 being the worst pain possible and zero being no pain, rate your complaints by circling the number:

Primary or chief complaint is:___________________________ : 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

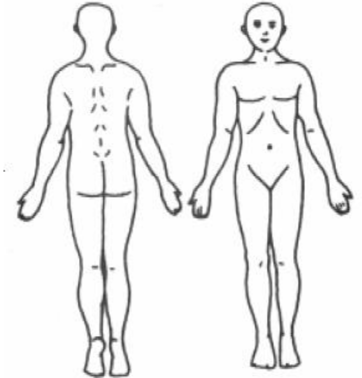
Second complaint is: _________________________________ : 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Third complain is: ___________________________________ : 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Fourth complaint is: _________________________________ : 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When did the primary problem(s) begin? _______________ When is the problem at its worst? ☐ AM ☐ PM ☐ Mid-day ☐ Late PM
How long does it last? ☐ It is constant **OR** ☐ I experience it on and off during the day **OR** ☐ It comes and goes throughout the week

How did the injury happen? ____



***PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms:
R = Radiating **B = B**urning **D = D**ull **A =** Aching **N = N**umbness **S = S**harp/ **S**tabbing **T= T**ingling

What relieves your symptoms? ____

What makes your symptoms feel worse? ____

Is your pain the result of ANY type of accident? ☐ Yes ☐ No Explain: ____________________
____

PAST HISTORY

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? _____________________ How did the injury happen?____________

* If you have ever been diagnosed with any of the following conditions, please indicate with a C for Currently have, P for past and N for Never have had:

C / P /N
☐ ☐ ☐ Broken Bone
☐ ☐ ☐ Dislocation
☐ ☐ ☐ Tumors
☐ ☐ ☐ Rheumatoid Arthritis
☐ ☐ ☐ Fracture
☐ ☐ ☐ Disability

C / P /N
☐ ☐ ☐Osteo Arthritis
☐ ☐ ☐ Diabetes
☐ ☐ ☐ Cerebral Vascular
☐ ☐ ☐ Cancer
☐ ☐ ☐Heart Attack
☐ ☐ ☐ Other Serious Conditions
Explain: ____

PLEASE identify ALL PAST and any CURRENT conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHO
INJURIES →			
SURGERIES →			
CHILDHOOD DISEASES→			
ADULT DISEASE →			

Daily Activities: Effects of Current Conditions on Performance
*Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

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
Recreational Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Shoveling	☐ 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
Reading	☐ 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

SOCIAL HISTORY

1. Smoking: ☐ cigars ☐ pipe ☐ cigarettes → How often? ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
2. Alcoholic Beverage: consumption occurs → How often? ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
3.Recreational Drug use: → How often? ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
4**. Hobbies -Recreational Activities- Exercise Regime**: How does your present problem affect the following, See pg 2- Activities

FAMILY HISTORY

1. Does anyone in your family suffer with the same condition(s)? ☐ Yes ☐ No
   If yes whom: ☐ Grandmother ☐ Grandfather ☐ Mother ☐ Father ☐ Sister's ☐ Brother's ☐ Son(s) ☐ Daughter(s)
   Have they ever been treated for their condition? ☐ Yes ☐ No ☐ I don't know
2. Any other hereditary conditions the doctor should be aware of. ☐ Yes ☐No Explain : ___________________________

Authorization

I hereby authorize payment to be made directly to New Journey Chiropractic for all benefits which may be payable under a healthcare plan or from any other collateral sources. 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 New Journey Chiropractic for any and all services I receive at this office.

____ _________-_________-_________
Patient or Authorized Person's Signature Date Completed

____ _________-_________-_________
Doctor's Signature Date Complete

Emotional

Rate your current level of **personal stress** in your life ☐ None ☐ Low ☐ Moderate ☐ High
Rate your current level of **relationship stress** in your life ☐ None ☐ Low ☐ Moderate ☐ High
Rate your current level of **financial stress** in your life ☐ None ☐ Low ☐ Moderate ☐ High
Rate your current level of **health stress** in your life ☐ None ☐ Low ☐ Moderate ☐ High
Rate your current level of **family stress** in your life ☐ None ☐ Low ☐ Moderate ☐ High
Rate your current level of **career stress** in your life ☐ None ☐ Low ☐ Moderate ☐ High
Do you feel you have a supportive network of friends and family? ☐Yes ☐ No
Do you feel you have healthy coping strategies for life stress? ☐Yes ☐ No

Chemical

Were you vaccinated as a child? ☐Yes ☐ No
Any adverse reactions to vaccine? ☐Yes ☐ No
Do you choose to have annual flu shots? ☐Yes ☐ No
Do you take antibiotics? ☐Yes ☐ No
How many glasses of water/day ☐ 0 ☐ 1-3 ☐ 4-6 ☐ 7-9 ☐+10
How many glasses of caffeinated beverages/day ☐ 0 ☐ 1-3 ☐ 4-6 ☐ 7-9 ☐+10
How many glasses of cow's milk, juice and pop/day ☐ 0 ☐ 1-3 ☐ 4-6 ☐ 7-9 ☐+10
Do you eat gluten? ☐Yes ☐ No
Do you eat dairy? ☐Yes ☐ No
Do you eat refined sugars? ☐Yes ☐ No
Do you eat boxed/frozen food? ☐Yes ☐ No
Do you choose organic foods? ☐Yes ☐ No
Do you eat any artificial sweeteners? ☐Yes ☐ No
Any food/drink allergies, sensitivities, intolerance? ☐Yes ☐ No
Do you smoke? ☐Yes ☐ No ☐ I used to ☐ I wish I didn't
Are you or have you been exposed to second-hand smoke? ☐Yes ☐ No
Do you drink alcohol? ☐Yes ☐ No ☐ 0-6/week ☐ 6-12/week ☐+12
Do you take a probiotic daily? ☐Yes ☐ No _____CFU's/day
Do you take vitamin D3 daily? ☐Yes ☐ No _____IU's/day
Do you take Omega 3 Fish oils daily? ☐Yes ☐ No _____ mg/day
Other supplements or homeopathic supplements? ____
Any other daily medication and their purpose____
Do you have a plan in place with your medical doctor to wean yourself off any long-term medications? ☐ Yes ☐ No

Family Health

At our clinic we are not only interested in your health and wellness but also the health and wellness of the important people in your life. Please mention below any health conditions or concerns you may have about your:

Children:____
Spouse:____
Mother:____
Father:____
Brother/Sisters:____
Are you seeking chiropractic care today for:

- ☐ Relief Care- Symptom relief of pain or discomfort
- ☐ Corrective Care- Correcting, relieving and stabilizing spinal, joint and postural issues
- ☐ Wellness Care- Maximizing the body's ability for optimal healing and function
- ☐ Pregnancy Care: regular care throughout pregnancy to optimize the growth and development of my baby and prepare my body for a heathy delivery and fast recovery.

Do you have other concerns we should know about? ____
____

QUADRUPLE VISUAL ANALOGUE SCALE

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 complain. Please indicate your pain level right now, average pain, and pain at its best and worst.

EXAMPLE:

					Headache				Neck Pain		Low Back	
No Pain	**0**	**1**	**2**	**3**	**(4)**	**5**	**6**	**7**	**(8)**	**9**	**(10)**	**Worst**

1. What is your pain right now?

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst

2. What is your <u>typical</u> or <u>average</u> pain?

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst

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

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst

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

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst

Other Comments:

____

____

____

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:
I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often 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 one 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 New Journey Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

____ _____/_____/_____ Witness Initials

Patient or Authorized Person' s Signature Date

Regarding: X-rays/Imaging Studies

FEMALES ONLY → please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.

- ☐ 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 to the best of my knowledge, I am not pregnant. By my signature below I am acknowledging that the doctor and or a 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.

____ _____/_____/_____ Witness Initials

Patient or Authorized Person's Signature Date

New Journey* Chiropractic's *NOTICE REGARDING YOUR RIGHT TO PRIVACY
I have received a copy of New Journey Chiropractic's Patient Privacy Notice. I understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this 'Notice of Privacy Practice" at an time in the future and will make the new provisions effective for all information that it maintains past and present. I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

____ ____/____/____ Witness Initials

Patient or Authorized Person's Signature Date

New Journey* Chiropractic's *NOTICE REGARDING OFFICE POLICIES
I hereby acknowledge receiving a copy of the practices 'Office Policies' a two page document, the first page of which I have read and retained. This second page is recognized by me as the signature page and will be retained by the practice as evidence of my receiving and understanding this 'Notice'. I further acknowledge that any concerns regarding these 'Policies 'as well as all my questions have been answered by a qualified member of the staff to my complete satisfaction.

____ _____/_____/_____ Witness Initials

Patient or Authorized Person's signature Date