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	C / P / N	C / P / N
☐ ☐ ☐ Headaches	☐ ☐ ☐ Upper Back Pain	☐ ☐ ☐ ADD/ADHD
☐ ☐ ☐ Facial Paralysis	☐ ☐ ☐ Hip pain	☐ ☐ ☐ Allergies
☐ ☐ ☐ Chronic Fatigue	☐ ☐ ☐ Back Curvature	☐ ☐ ☐ Incontinence
☐ ☐ ☐ Nausea/ Morning Sickness	☐ ☐ ☐ Scoliosis	☐ ☐ ☐ Digestive Problems
☐ ☐ ☐ Heartburn/ Indigestion	☐ ☐ ☐ Frequent Colds/Flu	☐ ☐ ☐Colon Trouble
☐ ☐ ☐ Preeclampsia	☐ ☐ ☐ Convulsions/Epilepsy	☐ ☐ ☐ Diarrhea/Constipation
☐ ☐ ☐ Gestational Diabetes	☐ ☐ ☐ Tremors	☐ ☐ ☐ Bed Wetting
☐ ☐ ☐ Constipation	☐ ☐ ☐ Chest Pain	☐ ☐ ☐ Learning Disability
☐ ☐ ☐ Hemorrhoids	☐ ☐ ☐ Pain w/ Coughing sneezing	☐ ☐ ☐ Eating Disorder
☐ ☐ ☐ Carpal Tunnel	☐ ☐ ☐ Foot or Knee Problems	☐ ☐ ☐ Trouble Sleeping
☐ ☐ ☐ Low/Midback pain	☐ ☐ ☐ Sinus/Drainage Problems	☐ ☐ ☐ Ulcers
☐ ☐ ☐ Breech or Side lying Presentation	☐ ☐ ☐ Swollen/Painful Joints	☐ ☐ ☐ Heart Problems
	☐ ☐ ☐ Skin Problems	☐ ☐ ☐ High Blood Pressure
☐ ☐ ☐ Round ligament Pain/Pulling	☐ ☐ ☐ Dizziness	☐ ☐ ☐ Low Blood Pressure
☐ ☐ ☐ Pain in your pubic bone	☐ ☐ ☐ Loss of Balance	☐ ☐ ☐ Asthma
☐ ☐ ☐ Pins/Needles in the Front/Side of your leg	☐ ☐ ☐ Fainting	☐ ☐ ☐ Difficulty Breathing
	☐ ☐ ☐ Double Vision	☐ ☐ ☐ Lung Problems
☐ ☐ ☐ Pain in Posterior Leg	☐ ☐ ☐ Blurred Vision	☐ ☐ ☐ Kidney Trouble
☐ ☐ ☐ Leg Cramps	☐ ☐ ☐ Ringing in Ears	☐ ☐ ☐ Gallbladder Trouble
☐ ☐ ☐ Swelling Ankles, Legs or Feet	☐ ☐ ☐ Hearing loss	☐ ☐ ☐ Liver Trouble
☐ ☐ ☐ Neck Pain	☐ ☐ ☐ Depression	☐ ☐ ☐ Hepatitis (A,B,C)
☐ ☐ ☐ Jaw pain, TMJ	☐ ☐ ☐ Irritable	
☐ ☐ ☐ Shoulder Pain	☐ ☐ ☐ Mood changes	

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

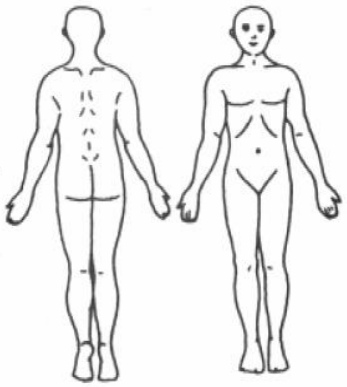
Second complaint is: _____ : 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

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 typical or average 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

PATIENT ACKNOWLEDGEMENT OF HIPAA NOTICE

Notice to Patient:

We are required to offer you a copy of our HIPAA notice which states how we may use and/or disclose your health information. Our HIPAA notice and office policies contain information regarding payment, health insurance, collections and other important information.

OPTIONAL Additional Items:

1) May we confirm your appointments by email, text or phone? Yes No

2) May we leave a message on your answering device at home or cell phone? Yes No

3) May we discuss your condition with any members of your family? Yes No

If yes, provide names: _____

4) We utilize open adjusting bays. We make good faith attempts to keep our conversations at a low level. We offer every patient the opportunity to hold private conversations in a private room if requested.

Are you comfortable being treated in an open bay? Yes No

Patient Acknowledgement:

I acknowledge and agree to this office's HIPAA notice. I acknowledge that I have reviewed the HIPAA notice and have the right to obtain a paper copy of the HIPAA notice. I acknowledge that I may refuse to sign this acknowledgment if I wish.

_____

Patient Printed Name

_____

Patient Signature or legal representative

_____

If legal representative, state relationship

_____

Date

FOR OFFICE USE ONLY:

We have made every effort to obtain written acknowledgment of receipt of our HIPAA notice from this patient but it could not be obtained because:

___ the patient refused to sign

___ we were not able to communicate with the patient

___ due to an emergency situation, it was not possible to obtain a signature

___ other (please provide details):

_____

Name of patient

_____

Name of staff member

_____

Signature of staff member

_____

Date

New Journey Chiropractic Appointment Policy

Consistency The Doctor's recommendations for your appointment consistency is directly related to the diagnosed condition of your spine. Our goal is to NOT ONLY relieve your expressed concerns but ultimately eliminate any subluxations that stop the nerves from functioning properly. Our desire is to prevent any further conditions/diseases from developing in the future which may inhibit you to do what you love with those you love. When your X-RAYS reveal a corrected spine, we know we both have accomplished that objective. We will always support you in staying committed to your health by guiding you to stay on track with your appointments as you build momentum with each adjustment. Cancelling appointments isn't an option. We ask you to reschedule any missed appointments immediately.

Walk-In's We are an Appointment Only practice. We are not able to accommodate Walk-In's. To make an appointment call 386-236-8085 or use our Phone App SKED.life for available appointment times.

Out of Town When you leave to go out of town, you'll need to "bulk up" your appointments before & after to make up for the missed time here in the office. Take your Home Care Therapy with you to utilize each day to stabilize the spine since no adjustments are received while you are away. This will continue the momentum & defer any regression of your spine.

Early or Late We understand you may be early or late for your appointment. However, we must keep the other patients and doctor on time.

If you have arrived "EARLY" please be respectful of others and wait until your "actual" scheduled time.

*If you are "LATE" (10 min past your appointment) we will have to reschedule the adjustment for the next available time.

No Call/No Show We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you don't show up at all, you may be preventing another patient from getting much needed care. When the schedule looks "full" and we turn someone away, we could have indeed helped them if we had known your appointment was available. We require you to contact us 1 hour before your appt to avoid any fees and allow others to schedule in your time slot.

1st No Call/No Show - Verbal warning 2nd No Call/ No Show -A $25 fee is charged to be paid before receiving your next adjustment and for every recurring No Call/No Show afterwards. Effective April 1, 2019.

_____ _____ _____

Print Name **Signature** **Date**