Ireland Chiropractic Clinic Health History Form - Pregnancy

Today's Date _____

PERSONAL DATA

Name _____ Age _____ Date of Birth _____

Home Address _____ City _____ State _____ Zip _____

Home phone (____) _____ Business Phone (____) _____

Cell Phone (____) _____ SS#_____

E-mail address_____@ _____

Occupation _____ Employer _____

Marital Status ❑ S ❑ M ❑ D ❑ W ❑ L/W Spouse/Partner _____

Names and Ages of Children_____

Whom may we thank for referring you to our office? _____

REASON FOR SEEKING CHIROPRACTIC CARE

Do you have a specific concern that brings you in?

❑ No, I'm interested in having my spinal and pelvic alignment assessed to help achieve optimal growth and delivery for myself and my baby

❑ Yes: _____

Are these concerns affecting your quality of life? (Please circle all that apply)

Work:	Y	N	Driving:	Y	N	Sleep:	Y	N
School:	Y	N	Walking:	Y	N	Sitting:	Y	N
Exercise/sports:	Y	N	Eating:	Y	N	Love life:	Y	N

HEALTH CARE PRACTITIONER HISTORY

Have you ever received Chiropractic care? ❑Y ❑ N Name of D.C. _____

How long under care? ❑ _____days ❑_____weeks ❑_____months ❑_____ years

Date of last visit: _____Why did you stop care?_____

Were spinal x-rays taken in the last 6 months? Y N

What was the primary reason for consulting that office?

❑ 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

Have you consulted or do you regularly consult any of the following providers? (check all that apply)

❑ Medical Physician ❑ Naturopath ❑ Acupuncturist ❑ Homeopath

❑ Massage Therapist ❑ Psychotherapist ❑ Energy Healer ❑ Dentist

Reason:_____

_____

Health, Wellness and Chiropractic Care

PREGNANCY PROFILE

What is your Estimated Due Date: _____

Name of OBGYN or Midwife

_____

Name of Doula:

_____

Where will you be birthing your baby? ❑ Hospital ❑ Home ❑ Birthing Center ❑

Other_____

What were cycles like prior to becoming pregnant?

_____

How long is a typical cycle? _____ How long was your bleed?

_____

Were any fertility methods used? Y N

Please indicate: ❑IVF ❑IUI ❑Clomid ❑Femara/Letozole ❑Other: _____

The primary system in the body which coordinates health is the NERVE SYSTEM.
The vertebrae (bones of the spinal column) surround and protect the delicate NERVE SYSTEM.
Injury to the SPINE and NERVE SYSTEM is a condition called VERTEBRAL SUBLUXATION.
VERTEBRAL SUBLUXATION results in nerve malfunction due to vertebral/spinal misalignment.

Vertebral Subluxations can have Physical, Emotional, and Chemical causes and effects.

The information below will help us to see the types of **PHYSICAL, EMOTIONAL & CHEMICAL** stresses you have been subjected to in your life, how they may relate to your present spinal, nerve, and health status and whether they may have caused **Vertebral Subluxations** to occur.

PHYSICAL STRESS: BIRTH AND INFANCY

The birth process can traumatize a baby's spine and cause damage to the spine & nerve system. Please CHECK where and how you were birthed. (If you do not know, please skip to next question)

❑ Home ❑ Natural ❑ Hospital ❑ Caesarian section ❑ Forceps

❑ Breech ❑ Cord around neck ❑ Prolonged labor ❑ Drug induced labor ❑ Suction

Health, Wellness and Chiropractic Care

PHYSICAL STRESS: CHILDHOOD THROUGH ADULT

The minor & often ignored repetitive physical traumas that we have endured are often too numerous to list. Please list the major traumas that you remember from your childhood up to the present.

Have you had any accidents due to any of the following? (Check all that apply)

❑ Automobile ❑ Motorcycle ❑ Bicycle ❑ Sports ❑ Playground ❑ Abuse

If yes, state type of injury and date:

_____

Have you ever hurt, broken, fractured, sprained, injured or felt pain in any bones or joints (spine, head, neck, ribs, chest, upper or lower back, pelvis or hips, legs or arms)? ❑ Y ❑ N

If yes, list body parts injured and dates of injuries:

_____

Have you ever been hospitalized or had surgery? ❑ Y ❑ N

If yes, state reason and dates: _____

EMOTIONAL STRESS: CHILDHOOD THROUGH ADULT

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if you have ever or are experiencing any of the emotional stresses below:

Childhood Trauma	Y	N	Loss of loved one	Y	N	Abuse	Y	N
Work or School	Y	N	Divorce/separation	Y	N	Financial	Y	N
Lifestyle change	Y	N	Parents divorce	Y	N	Illness	Y	N

CHEMICAL STRESS: CHILDHOOD THROUGH ADULT

Chemical stress can occur when a substance, that is toxic to the body, is breathed, injected, taken by mouth, or placed on the skin (e.g.: food allergies, drug reactions, exposure to chemicals in the air, etc.) The following will reveal exposures you may have had.

Were you vaccinated? ❑ Y ❑ N If yes, did you have a reaction? ❑ Y ❑ N ❑Unsure

Have you been exposed to any of the following on a regular basis (either in the past or presently)?

❑ Toxic chemicals ❑ Second hand smoke ❑ Drug therapy

❑ Radiation ❑ Chemotherapy ❑ Other

If yes, please list:_____

Do you have allergies or sensitivities to any foods? ❑ Y ❑ N If yes, please list:

_____

Do you presently consume any of the following?

❑ Coffee/caffeine ❑ Alcohol ❑ Tobacco ❑ Over the counter drugs ❑ Prescribed drugs

Please list all medications (prescribed and over the counter):_____

_____

_____

Note: It is imperative that you list all medications as they may have an influence on your care.

QUALITY OF LIFE (presently)

How do you grade your physical health?	❑ Good	❑ Fair	❑ Poor
How do you grade your emotional/mental health?	❑ Good	❑ Fair	❑ Poor
How do you rate your overall “quality of life”?	❑ Good	❑ Fair	❑ Poor

Do you exercise regularly? If yes, how often? _____

Do you take supplements? If yes, please list: _____

Do you follow a special dietary regime? _____

Information About Finances

Payment in full is expected on all FIRST VISIT services. All other fees are to be paid at time of service until other arrangements have been made and agreed upon in writing.

Please indicate your method of payment. ❑ Cash ❑ Check ❑ Credit Card

The fee for the first visit is **$65** (consultation and exam)

PLEASE READ AND SIGN

1. I acknowledge that Ireland Chiropractic Clinic has informed me that Dr. Jessica Steenstra is in network with certain insurance companies. It is a courtesy for Ireland Chiropractic Clinic to find out benefit information but it is NOT a guarantee of coverage. Insurance companies hold the right to deny care if not seen as medically necessary. Insurance companies also do NOT cover wellness or preventive care. Therefore any care deemed as wellness or preventive will not be billed to insurance company and is 100% patient responsibility.
2. I have been informed that all deductible amounts must be paid by me at time of service. I have also been informed that any changes to insurance policy (ie. New cards, new carrier) is my responsibility to supply this information to Ireland Chiropractic Clinic or charges will become my responsibility.
3. I have been informed that I am being treated for vertebral subluxation NOT any disease or condition that may have been diagnosed by another healthcare professional. Our goal at Ireland Chiropractic Clinic is to treat by specific adjustments to correct vertebral subluxations.

4. I have been informed that a copy of Ireland Chiropractic Clinic *"Notice of Privacy Practices for Protected Health Information (HIPAA)"* brochure is available for my review in the office.

5. I consent to receive communication from Ireland Chiropractic Clinic via email, postal mail, text and telephone messaging in conection with my care.
   ❑ Yes ❑ No If I should withdraw my consent, I will notify the office in writing.

6. I consent to being treated in an open adjusting area. ❑ Yes ❑ No If I should withdraw my consent, I will notify the office in writing and then be treated in a closed room.

7. I consent that the following is a secondary contact to be used for an emergency or I cannot be reached.

   Name:
   Address:
   Phone Number:

The information I have provided on this case history form is true and accurate to the best of my knowledge. I give Dr. Jessica Steenstra permission to render care to me today. This initial visit includes a health history consultation, chiropractic exam and evaluation, and any initial care that is determined to be clinically necessary and mutually agreed upon.

Name: (Printed) _____Date: _____

Signature:_____

Signature of Parent (for minor):_____ Date: _____

Thank you for choosing Ireland Chiropractic Clinic.
We look forward to helping you.