Pregnancy Health History Form

Name: _____
Date:_____
Age: _____ Birth date: dd/mm/yyyy _____ Sex: F Patient Number: ____
E mail address: _____
Address:_____
Phone:(H)_____ (W)_____ (cell) _____ Marital Status: S M W D CL
Occupation: _____ Who may we thank for referring you?_____
Family doctors name and address: _____

WHY THIS FORM IS IMPORTANT Our focus is on assisting clients to function optimally, for them to become more self aware, stronger, healthier and for improved adaptation to everyday stresses. Completion of this form provides us with an improved understanding of your physical, emotional and chemical stresses that can gradually overwhelm the body over time and contribute to health problems. Please complete this form as thoroughly as possible and the doctor will review it with you. Information on this form is strictly confidential and will not be shared without your consent.

#1 Current Health Concern (if there are no current concerns and this assessment is to ensure optimum health, function and wellness tick this box) ☐

 # 2 About Your Pregnancy: (circle answer)
Is this your first pregnancy? Yes / No
If this is not your first, how many times have you been pregnant? _____
Have you had any complications with previous pregnancies? **Yes / No** (explain if yes)
_____
If you have had miscarriage(s), how far along in your pregnancy did it occur?
_____
Was this pregnancy planned? **Yes / No**
What is the estimated date of delivery? _____
Who is your primary care giver for delivery? Obgyn / GP/ Midwife? Name: _____
What is your planned location for delivery? Hospital / Home/ Birthing clinic/other
How do you feel about this pregnancy? _____
Have you a birth plan? **Yes / No**
Would you like information on creating one? **Yes / No**
Any special arrangements for the birth? (planned C-sec, water delivery, birth chair, squat, other)_____
Would you like additional information on options for birth posturing? **Yes / No**
Have you had any testing? Genetic, blood, ultrasound, amniocentesis, chorionic villi sampling, other)?
Dates and reasons: _____
Are you planning on breastfeeding post delivery? **Yes / No**

Pregnancy Health History Form

Would you like further information on the advantages of breastfeeding? **Yes / No**
Was you blood pressure prior to pregnancy within normal range, low or high? _____
What is your present blood pressure and when was it last checked? _____
Have you changed your diet/menu since learning of your pregnancy? **Yes / No**
Would you like further information on healthy nutrition for pregnancy? **Yes / No**
Have you smoked prior to or along with this pregnancy? **Yes / No / Quit** _____
Have you had alcohol during this pregnancy? **Yes / No** _____

Have you noticed:
Swelling in the arms or legs? (circle) **Yes / /No**
Low back pain? **Yes / No** How often? _____
Upper back pain? **Yes / No** How often? _____
Neck pain? **Yes / No** How often? _____
Rib or chest pain? **Yes / No** How often? _____
Any foot pain? **Yes / No** How often? _____
Digestive complaints? Heartburn, constipation? **Yes/ No** _____
Nausea or vomiting? **Yes / No** Frequency and when? _____
Arm or hand numbness/tingling? **Yes / No** How often? _____
Dizziness or lightheadedness? **Yes / No** How often? _____
Headaches? **Yes / No** How often?
Pain radiating down the leg(s)? **Yes / No** How often? _____
Heart palpitations? **Yes / No** How often? _____

If pain from anything noted above is involved, rank it on a scale of 1 to 10 (1 is minimal, 10 is extreme) _____
Circle or describe it's character (sharp, dull, ache, burning, tingling, throbbing, spasms, other) _____
When did you notice it?_____
What happened? _____ What relieves?_____
What aggravates?_____
Does it radiate or cause problems elsewhere? _____
Any associated or related concerns? _____
Professionals seen for this? (name) _____
Treatment and results_____

Other health concerns: Please note all other health concerns present or in the past.
Diseases history: (please circle all that apply)
Allergies, Stuffy nose, Runny sinuses, Frequent colds, Lowered resistance, Loss of balance, Difficulty concentrating, Fatigue, Indigestion, Bloating, Appendicitis, Asthma, Bronchitis, Emphysema, Pneumonia, Bleeding disorders, Cancer, Cataracts, Vision changes, Diabetes, Hypoglycemia, Epilepsy, Heart Disease, Hypertension, Migraines, Hepatitis, High cholesterol, Difficulty digestion, Loose stools, Hernia, Herniated Disc, Kidney Disease, Liver disease,

Pregnancy Health History Form

Multiple Sclerosis, Osteoarthritis, Rheumatoid arthritis, Osteoporosis, Parkinson's Disease, Thyroid problem, Tonsillitis, Ulcers, Urinary tract infections, Ulcerative colitis Other (list):

_____

#3 Physical stresses

Any significant injuries, falls or traumas during infancy or childhood? **Yes No Unsure**
(if yes please explain) _____
Any significant injuries, falls or traumas (car accidents) during adulthood? **Yes No Unsure**
(if yes please explain) _____
Any hospital visits? **Yes No**
Explain_____ Have you had any surgeries, fractures? **Yes No** Explain and dates _____
Are you in prolonged postures (ex: repetitive work, lifting, sitting, driving) **Yes No Unsure**
(if yes, please explain)_____
Any hobbies that are physically strenuous or have repetitive movements? **Yes No Unsure**
(if yes, please explain)_____
What is your usual exercise routine? _____
Any fractured bones or dislocations? _____
Any vehicle accidents? **Yes No** What happened and when? _____

#4 Chemical Stresses

Are you taking prescription or over-the-counter medications? **Yes / No** (If yes, please indicate what you are taking and why)

_____
Are you currently taking supplements? **Yes / No**(if yes, which ones and why?) _____
_____
Do you drink bottled water? **Yes / No / Occasionally**
Are you exposed to pollutants, strong smells, chemicals, aerosols? **Yes No Occasionally**
Do you eat organic? **Yes / No / Occasionally**
Do you use natural or environmentally friendly products in your home? I.E. Cleaning supplies, hair and makeup, etc. **Yes / No** _____
Do you drink or bathe/shower in chlorinated water? **Yes / No** _____

#5 Mental/Emotional Stresses

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 I feel _____ Work and Career I feel _____ Relationships I feel _____
Financial stress I feel _____ Time management I feel _____ Sports & hobbies I feel ____
Health and well-being I feel _____ Quality of sleep I feel _____ About my pregnancy I feel _
If you are experiencing significant or ongoing stress please explain _____
_____
Do you practice some form of meditation, breath work, other mind-body movement or have a

Pregnancy Health History Form

routine to reduce your stress? Yes /No Explain _____
Are you interested in learning about stress reduction practices? Yes / No

#6 Family Health History

Please note any health issues that are present with family members such as parents, siblings, significant other or children. Cancer, hypertension, stroke, arthritis, kidney disease, dementia, diabetes, other

_____

#7 Why are you here?

People seek chiropractic care for a number of reasons and have certain expectations and perceptions. Please tick 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 and quality of life ____ Improved performance _____ Full body integration_____ Wellness _____
Longevity _____ Other_____

CONSENT for examination and care once a report if findings has been reviewed: Please Read Carefully

In order for my health professional as indicated below to make a determination on the suitability of my case for care, I acknowledge and understand that I must complete a thorough evaluation. I do hereby request and consent to the performance of such an evaluation by the person(s) named below, or any party authorized to do so by that person.

I have had the opportunity to discuss with the Doctor of Chiropractic indicated below, or with any party authorized to do so by that Chiropractor, about the nature and purpose of the examination process. I understand that there may be remotely associated risks with examinations, as there are with any and all healthcare treatments. In healthcare, the matter of whether any treatment is appropriate or not is determined by looking at the level of risk and comparing this with the level of expected benefit. I understand that I may ask the doctor to stop the examination at any time. I also understand that by signing this form, the chiropractor continues to be obligated for best practices delivered in my interests.

Name: _____ Date:_____

Signature:_____ **Witness:**_____

Doctor of Chiropractic:
Address:

BUCKEYE CHIROPRACTIC & WELLNESS
SYNERGY MEDICAL
CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic manipulation and manual therapy techniques and other chiropractic procedures, including various modes of physical therapeutic modalities and procedures and diagnostic X-rays, where warranted, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below.

I have had an opportunity to discuss with the doctor of chiropractic named below the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment and diagnostic services including but not limited to:

Manipulation: increased pain or discomfort, fractures, disc injuries, strokes, dislocations and sprains.

Therapeutic Modalities and procedures: additional pain and discomfort. Endurance exercise may cause increased risk of acute Myocardial Infarction (heart attack) in patients with known or possible cardiac conditions.

Radiographs: ionizing radiation can be harmful to a fetus for those who are pregnant or might be pregnant.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. The doctor named below has additionally explained the risks associated with my refusal of treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient/Guardian Signature_____ Date _____

Witness Signature _____ Date_____

Female Only

_____ I am NOT pregnant.

_____ I am pregnant.

Buckeye Chiropractic & Wellness/Synergy Medical
16705 Square Dr. Marysville, OH 43040
(937)642-4400 (p) ~ (937)642-4443 (f)

Protecting Your Health Information

New Regulation Passed

This new regulation is part of the Health Insurance Portability and Accountability Act or HIPPA and does three primary things:

1. It helps standardize and simplify the way healthcare organizations exchange health care data.
2. It provides consumers with additional protections for getting and maintaining health insurance coverage although, it does not guarantee coverage.
3. It creates new security rules to ensure the safety and privacy of individuals and medical records.

Our Pledge Regarding Medical Information

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed protecting it. We create a record of the care and services you receive at our office. We need the record to provide you with the quality care and to comply with certain legal requirements. In addition, we have a policy in effect that makes every attempt to maintain the confidentiality of all patients' information.

Disclosure of Medical Information

In addition to disclosing your medical information for treatment, payment and health care operations, we may disclose medical information for the following purpose: for a court order, subpoena, discovery request or other lawful process. We may disclose medical information to appropriate authorities if we reasonably believe that you are the victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose health information when authorized and necessary to comply with laws relating to worker's compensation, auto accidents, personal injury or similar issues.

If someone calls or comes by, they will not be given any information about your care and/or appointments unless otherwise specified and noted in your file.

We will also be publicly noting your name in our newsletter and/or picture in our lobby unless otherwise specified. Upon becoming a patient, we will be entering your name and email into our database and you may receive our monthly newsletter. If you do not wish to receive our newsletters, please contact our office and advise the receptionist of such. This list will not be sold to any outside agencies.

Your Rights

You have the right to look at or get copies of your medical records and to receive a list of all the times we shared your medical information for purposes other than treatment, payment and health care operations.

Open Adjusting Concept

Because of the open adjusting concept in this office, it is possible for doctor/patient discussions to be overheard by other patients. Most discussions will involve spinal health, but may include anything concerning the primary health care of that patient.

Notification by Mail or Phone

Patients may be contacted by mail, email, or phone unless written notification is requested that contact be only in person.

Complaints

If you feel that your rights have been violated, contact the Office Manager or the U.S. Department of Health and Human Services.

Patient/Guardian Signature:_____ Date:_____

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS
AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE
AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay **Buckeye Chiropractic/Synergy Medical, Doctor Charita Cooper, Doctor Patrick Cooper, and Rachel Frinak CNP** as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that ***have been* or *will be*** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Signed this _____ day of _____, 20 ____. X_____
(SEAL)

(patient signature)

X_____(SEAL) X_____
(signature of Guardian if applicable) (please print patient name)

Rachel G. Frinak, MS APRN FNP-C Charita N. Cooper, DC CACCP Patrick S. Cooper, DC CCEP

When it comes to your health, chiropractors and medical doctors should be working together for your benefit!

I agree! I give you permission to inform my primary care physician of my condition, treatment and expected/actual response to care at this office.

Patient/Guardian Signature: _____

Name (Please Print): _____

Primary Care Physician: _____

Physician's Address/Phone: _____

_____

Synergy Medical

16705 Square Drive

Marysville, OH 43040

P. 937.642.4400 F. 937.642.4443

SynergyMedicalTeam.com