newbeginnings chiropractic

making your health a priority

PRENATAL HEALTH QUESTIONNAIRE

1 CURRENT PREGNANCY

You are here for (choose all that apply): ◯ Wellness ◯ Discomfort ◯ Baby Position

Position of baby: ◯ Unknown ◯ Breech ◯ Transverse ◯ Posterior ◯ Vertex

_____ # WEEKS PREGNANT

_____ ANTICIPATED DUE DATE

GENDER OF BABY: ◯ M ◯ F ◯ Dont Know yet ◯ Not Finding out This is Baby #: _____

Birth Plan (Specify where): ◯ Home Birth ◯ Birth Center: _____

◯ Hospital: _____

Your Delivery Plan (please specify who) : OB/GYN: _____

Midwife: _____ Doula: _____

May we have your permission to contact your pre-natal provider regarding your care? ◯ NO ◯ YES

2 PREVIOUS PREGNANCIES

NUMBER OF PREVIOUS PREGNANCIES: _____ NUMBER OF PREVIOUS DELIVERIES: _____

DELIVERY COMPLICATIONS (circle): None Forceps Vacuum extraction Cesarean

Please explain any delivery complications: _____

_____

_____

If there was a cesarean, what was the reason? _____

_____

_____

3 OTHER INFORMATION

I AM INTERESTED IN MORE INFORMATION ON THE FOLLOWING:

◯ Infant & toddler Chiropractic
◯ Prenatal Yoga
◯ Prenatal Massage
◯ Prenatal Acupuncture
◯ Prenatal support belts
◯ Baby Wearing
◯ Birthing Classes
◯ Doula recommendation
◯ Midwife recommendation
◯ OB/GYN recommendation
◯ Pregnancy photography
◯ Lactation Consultant
◯ Breast pump recommendation
◯ Meal Planning
◯ Postpartum emotional wellness

PATIENT NAME (PRINT) PATIENT SIGNATURE DATE

Webster Consent

Please initial each statement

_____I acknowledge that the Webster technique it a specific Chiropractic analysis and diversified adjustment. The goal of the adjustment is to establish balance to the structure (joints, muscles, and ligaments) of the mother's pelvis, improving neuro–biomechanical function and allowing the uterus to enlarge symmetrically with the growing baby.

_____I acknowledge that due to the cumulative effect of stress and trauma to the spine, pelvis, and sacrum over a lifetime, the diameter of the pelvic opening may be compromised which can lead to intrauterine constraint. According to Williams Obstetrics text, any diminished capacity of the pelvis or displacement of the sacrum can lead to dystocia (difficulty) during labor. The correction of these misalignments via the Webster Technique, can have a positive effect on (A) the mother's comfort level throughout pregnancy, (B) the ability of the baby to get into optimal positioning for birth, and (C) the causes of difficult labor.

_____I acknowledge that this is not a breech turning technique or External Cephalic Version procedure and that the Doctor will in no way be manually manipulating the baby's positioning. Often mothers report feeling an increase in the baby's movement later on in the day following an adjustment, which is considered positive because it indicates that the baby now has more room to do so.

_____I understand that in rare cases it is possible to have some minor soreness after my first few adjustments, especially if I have never been adjusted before. My Chiropractor will give me specific at home instruction to help avoid this.

_____I acknowledge that Chiropractic care throughout pregnancy allows for healthier function of the mother and baby. The Webster Technique is tailored to pregnant moms to create balance in the mother's pelvic bones, sacrum, and surrounding muscles and ligaments, therefore reducing the possibility of intrauterine constraint. This offers the baby to get into the best possible positioning for birth which can lead to a safer easier delivery. Chiropractic care during pregnancy is a safe, effective way to support the natural process of birthing.

_____I acknowledge that all Chiropractic care provided to me in the office will be performed by a licensed, experienced, certified Webster Technique Doctor of Chiropractic.

_____I authorize New Beginnings Chiropractic to provide my OBGYN or Midwife medical records as needed.

_____ _____

Patient Name (printed) Signature

Date: _____

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ADULT
PATIENT INFORMATION

INSURANCE INFORMATION: Please present your insurance card(s) at time of service. If you have primary **AND** secondary insurance please inform the front desk, so there is no discrepancy with your claims.

1 PATIENT DEMOGRAPHICS

FIRST NAME _____ LAST NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____ GENDER ◯ M ◯ F

EMAIL _____ *This will be used to email receipts, for future newsletter mailings or massage specials only. It will not be solicited.*

BIRTH DATE MM|DD|YYYY _____ AGE _____ IS YOUR VISIT TODAY DUE TO A: ◯ CAR ACCIDENT ◯ WORKERS COMPENSATION

STATUS ◯ SINGLE ◯ MARRIED ◯ DIVORCED ◯ OTHER _____

HOW DID YOU HEAR ABOUT OUR OFFICE? ◯ GOOGLE/ OTHER _____

◯ EXISTING PATIENT _____ ◯ ANOTHER PROVIDER _____

2 EMERGENCY CONTACT

FIRST NAME _____ LAST NAME _____

RELATIONSHIP TO PATIENT _____ PHONE _____

YOUR PRIMARY DOCTOR _____ PHONE _____

3 EMPLOYMENT INFO

EMPLOYMENT STATUS ◯ FULL-TIME ◯ SELF-EMPLOYED ◯ STUDENT ◯ PART-TIME ◯ UNEMPLOYED ◯ RETIRED

EMPLOYER _____ OCCUPATION _____ WORK PHONE _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

You may be asked to sign a Patient Authorization to Release Information, as we would want to request information from other providers that have participated in your care. This will help insure that we have all information concerning your condition.

4 INSURANCE INFORMATION

PATIENT NAME ON INSURANCE CARD (PRINT) _____ DATE POLICY ACTIVE _____

NAME OF INSURANCE CARRIER _____

Do you have insurance? ◯ Yes ◯ No POLICY NUMBER _____ GROUP NUMBER _____

1. **Describe your symptoms *presently:*** _____

When & how did your symptoms start? _____

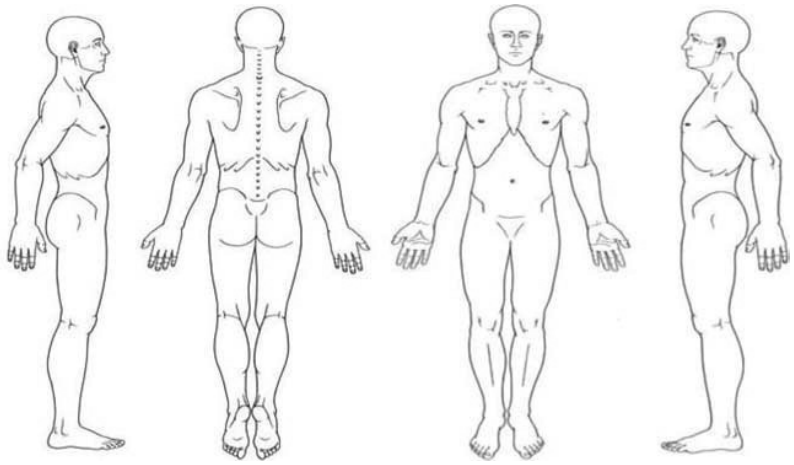
What makes it better/worse? _____

2. **How often do you experience your symptoms?**
   - ◯ Constantly (76-100% of the day)
   - ◯ Frequently (51-75% of the day)
   - ◯ Occasionally (26-50% of the day)
   - ◯ Intermittently (0-25% of the day)

3. **What describes the nature of your symptoms?**
   - ◯ Sharp ◯ Shooting ◯ Radiating
   - ◯ Dull ache ◯ Burning
   - ◯ Numb ◯ Tingling

4. **What describes the nature of your symptoms?**
   - ◯ Getting Better
   - ◯ Not Changing
   - ◯ Getting Worse

Indicate where you have pain or other symptoms



5. **During the past 4 weeks:**
   Indicate the average intensity of your symptoms

NONE 0 1 2 3 4 5 6 7 8 9 10 UNBEARABLE

How much has pain interfered with your normal schedule? (Including work and home)
◯ All of the time ◯ Most of the time ◯ Some of the time ◯ A little of the time ◯ None of the time

How much of the time has your condition interfered with your social activities?
◯ All of the time ◯ Most of the time ◯ Some of the time ◯ A little of the time ◯ None of the time

6. **In general would you say your overall health is right now.**
   ◯ Excellent ◯ Very Good ◯ Good ◯ Fair ◯ Poor

7. **Who have you seen for your symptoms?** ◯ Chiropractor ◯ Medical Doctor ◯ Physical Therapist ◯ Other
   What treatment did you receive and when? _____

   What tests have you had for your symptoms? ◯ Xrays DATE _____ ◯ CT Scan DATE _____
   ◯ MRI DATE _____ ◯ Other DATE _____

8. **Have you had similar symptoms in the past?** ◯ Yes ◯ No
   If you have received treatment in the past for the same or similar symptoms, who did you see? ◯ This Office ◯ Medical Doctor ◯ Other ◯ Chiropractor ◯ Physical Therapist

9. **Is your pain:** ◯ worse in morning ◯ worse at night ◯ worse with cough/sneeze ◯ disrupting sleep

Have you ever been to a chiropractor before? ◯ Yes ◯ No

If YES, when was your last adjustment: DATE _____ Were your goals met with this chiro? ◯ Yes ◯ No

PATIENT SIGNATURE _____ DATE _____

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PATIENT NAME (PRINT) _____ DATE _____

What Activities of Daily Living does your current condition effect (self-care, driving, stairs etc)? _____

What type of regular exercise do you perform? ◯ None _____

What is your height and weight? Height [ ][ ][ ] Weight [ ][ ][ ] lbs
FEET INCHES

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

PAST	PRESENT		PAST	PRESENT		PAST	PRESENT	
◯	◯	Headaches	◯	◯	High Blood Pressure	◯	◯	Diabetes
◯	◯	Neck Pain	◯	◯	Heart Attack	◯	◯	Excessive Thirst
◯	◯	Upper Back Pain	◯	◯	Chest Pains	◯	◯	Frequent Urination
◯	◯	Mid Back Pain	◯	◯	Stroke	◯	◯	Smoking/Use Tobacco
◯	◯	Low Back Pain	◯	◯	Angina	◯	◯	Drug/Alcohol Dependence
◯	◯	Shoulder Pain	◯	◯	Kidney Stones	◯	◯	Depression
◯	◯	Elbow/Upper Arm Pain	◯	◯	Kidney Disorders	◯	◯	Systemic Lupus
◯	◯	Wrist Pain	◯	◯	Bladder Infection	◯	◯	Epilepsy
◯	◯	Hand Pain	◯	◯	Painful Urination	◯	◯	Dermatitis/Eczema/Rash
◯	◯	Hip/Upper Leg Pain	◯	◯	Loss of Bladder Control	◯	◯	Digestive Issues
◯	◯	Knee/Lower Leg Pain	◯	◯	Prostate Problems			
◯	◯	Ankle/Foot Pain	◯	◯	Abnormal Weight Gain/Loss			**Females Only**
◯	◯	Jaw Pain	◯	◯	Loss of Appetite	◯	◯	Birth Control Pills
◯	◯	Joint Swelling/Stiffness	◯	◯	Abdominal Pain	◯	◯	Hormonal Replacement
◯	◯	Arthritis	◯	◯	Ulcer	◯	◯	Pregnancy/How many?____
◯	◯	Rheumatoid Arthritis	◯	◯	Hepatitis			
◯	◯	General Fatigue	◯	◯	Liver/Gall Bladder Disorder			**Other Health Issues** list
◯	◯	Muscular In-coordination	◯	◯	Cancer			below:
◯	◯	Visual Disturbances	◯	◯	Tumor	◯	◯	_____
◯	◯	Dizziness	◯	◯	Asthma	◯	◯	_____
			◯	◯	Chronic Sinusitis			

Do you have any **allergies**? (to food/medication/seasonal)? _____

Indicate if any immediate family member has had any of the following:

◯ Rheumatoid Arthritis ◯ Heart Problems ◯ Diabetes ◯ Cancer ◯ Lupus ◯ Other _____

List ALL prescriptions, over-the-counter medications, and nutritional supplements you are taking:

_____ _____ _____

_____ _____ _____

List ALL surguries/hospitalization/conditions/car accidents/sports injuries (even if you got no treatments for them)

_____ _____ _____

_____ _____ _____

_____ _____
PATIENT SIGNATURE DATE

Doctor's Additional Comments

_____ _____
DOCTOR SIGNATURE DATE

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*PREFERRED METHOD OF CONTACT FOR APPOINTMENT REMINDERS:

○ TEXT ○ EMAIL ○ BOTH

FINANCIAL POLICY

1. Please verify your chiropractic benefits with your health insurance company. When our staff calls on your benefits they only give us an outline of benefits, not a guarantee of payment. All benefits are subject to the terms and exclusions of your policy.
2. Your insurance will make payments for any authorized and/or covered services. You are required to pay for services and materials that your insurance does not cover.
3. If your insurance requires a referral from another provider, we will require information of the referral to process your insurance with in-network benefits. Until this information is provided to us, we require you to pay all co-pays, deductibles and/or co-insurance relating to out-of-network benefits. Any over payments to your account will be reimbursed to you after insurance pays their portion.
4. If your insurance carrier has not paid your claim within sixty days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid your claim within ninety days of submission, you accept full responsibility for payment of any outstanding balance. If your account becomes delinquent and consequently gets forwarded to a collections agency, you accept full responsibility of all charges.
5. I hereby authorize payment to be made directly to New Beginnings Chiropractic LLC 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 Beginnings LLC for any and all services I receive at this office.

I have read and understand and agree to abide by the information stated above as it applies to my coverage.

PATIENT NAME (PRINT) PATIENT SIGNATURE DATE

INFORMED CONSENT TO CHIROPRACTIC TREATMENT & HIPAA NOTICE

I hereby request and consent to the performance of chiropractic procedures, including a comprehensive exam, diagnostic testing, physical therapy techniques, massage or manual therapy, adjustments or manipulation, and acupuncture on me which are recommended by the doctors at New Beginnings Chiropractic, and/or other licensed doctor of chiropractic who now or in the future render treatment to me while employed by or associated with New Beginnings Chiropractic. I have had an opportunity to discuss with the physician and/or with other office personnel 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 and all healthcare, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures, muscle sprain/strain, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels are in my best interests at the time, based upon the facts then known.

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

PATIENT NAME (PRINT) PATIENT SIGNATURE DATE

I consent to the use or disclosure of my protected health information by New Beginnings Chiropractic for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of New Beginnings Chiropractic. I understand that analysis, diagnosis or treatment of me by New Beginnings Chiropractic may be conditioned upon my consent as evidenced by my signature below. I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment payment or healthcare operations of this practice. New Beginnings Chiropractic is not required to agree to the restrictions that I may request. However, if New Beginnings agrees to a restriction that I request, the restriction is binding on New Beginnings Chiropractic. I have the right to revoke this consent, in writing, at any time, except to the extent that New Beginnings Chiropractic has taken action in reliance on the consent.

My protected health information means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, and health plan, my employer or a health care clearinghouse. This protected health information relates to my past,present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me. A full copy of HIPAA policies are available upon request.

PATIENT NAME (PRINT) PATIENT SIGNATURE DATE