

Case History for Pregnant Patient

Date _____

Name _____ Date of Birth _____

Home Telephone _____ Work Telephone _____

Name of Husband _____ Husband's Employment _____

Insurance Information _____

Did a health problem prompt you to visit a chiropractor? _____ Explain _____

Previous Major Illness or Surgery _____

Medications you are currently taken or have taken since conception _____

Allergies _____

Do you smoke? _____ (If no did you ever smoke)? _____ How Long _____

Do you drink? None _____ Social (Fewer then 2 daily) _____ Heavy (2 or more daily) _____

List the foods you eat daily and summary of your diet habits

What type of exercises do you do? _____

Age at last menstrual cycle? _____ Length of regular menstrual cycle? _____

Are your cycles regular? Always _____ Most of the time _____ Never _____

Date of your last menstrual cycle _____ Was it normal? _____

Date of last x-rays if any? _____ Why and by whom? _____

Have you had any previous pregnancies? _____ Explain _____

Have you had past cesareans? _____ How many? _____

Have you had a previous D&C? How many and dates? _____

Do you have any of the following?

Diabetes _____ Asthma Rh negative blood _____ Other chronic problems _____

Have you taken birth control pills? _____ Type _____

Have you used an IUD? _____ Date of removal _____

Did you have any health problems during previous pregnancies? _____

Explain _____

Have you ever received chiropractic care? _____ Dr's. Name _____

Results _____

Who referred you to our office? _____

Name of your obstetrician? _____

Nurse/Midwife? _____

Other _____

Where do you plan to have your baby? _____

What symptoms of pregnancy have you already experienced? _____

Additional comments _____

Personal and Family Health History

Name _____
 Date _____
 Address _____
 City _____ State _____ Zip _____
 Phone: (H) _____ (W) _____
 E-mail _____
 Date of Birth _____ (Age _____)

Referred By _____
 Social Security # _____
 Occupation _____
 Employer _____
 Marital Status S M D W
 Spouse's Name _____
 Spouse's Occupation _____

Number of Children and Ages

Name _____ Age _____ Yes ___ No ___ Reason _____
 Name _____ Age _____ Yes ___ No ___ Reason _____
 Name _____ Age _____ Yes ___ No ___ Reason _____
 Name _____ Age _____ Yes ___ No ___ Reason _____

Previous Chiropractic Care?

You deserve to be healthy. Life is a miracle and so are you. When you were created, you were given all the blueprints, intelligence, tools, and systems to live an active healthy life. Unfortunately, your health can be interfered with through accidents and challenges that cause a disruption to your health expression. Through your examination and through your lifetime involvement in chiropractic care, we will work to remove these interferences to your natural health expression so that you can live the quality of life you deserve.

Circle all that Apply

1. Was Your Birth Traumatic?

	Patient	Spouse	Child#1	Child#2	Child #3	Chiropractor's Comments
Long Delivery?	Y	Y	Y	Y	Y	_____
Difficult Delivery?	Y	Y	Y	Y	Y	_____
Forceps?	Y	Y	Y	Y	Y	_____
Caesarian?	Y	Y	Y	Y	Y	_____
Breach/cephalic?	Y	Y	Y	Y	Y	_____
Home birth?	Y	Y	Y	Y	Y	_____
Mother given drugs during delivery	Y	Y	Y	Y	Y	_____
Induced Labor?	Y	Y	Y	Y	Y	_____

2. Growth and Development

Did you ever once...

	Patient	Spouse	Child#1	Child#2	Child #3	Chiropractor's Comments
Learn to care for your spine?	Y	Y	Y	Y	Y	_____
Fall out of bed?	Y	Y	Y	Y	Y	_____
Bang your head?	Y	Y	Y	Y	Y	_____
Breastfeed?	Y	Y	Y	Y	Y	_____
Childhood sickness?	Y	Y	Y	Y	Y	_____
Have any Accidents?	Y	Y	Y	Y	Y	_____
Have Surgery?	Y	Y	Y	Y	Y	_____
Take Drugs?	Y	Y	Y	Y	Y	_____
Fall while learning to walk?	Y	Y	Y	Y	Y	_____
Bullied by your siblings?	Y	Y	Y	Y	Y	_____
Child abuse	Y	Y	Y	Y	Y	_____
Spanking?	Y	Y	Y	Y	Y	_____
Pulled ear/chin	Y	Y	Y	Y	Y	_____
Other	Y	Y	Y	Y	Y	_____
Chair pulled out when sitting?	Y	Y	Y	Y	Y	_____
Fall down the stairs?	Y	Y	Y	Y	Y	_____
Pulled by your arm?	Y	Y	Y	Y	Y	_____
Experience other traumas?	Y	Y	Y	Y	Y	_____

3. Current Health Habits

Did/do you...

	Patient	Spouse	Child#1	Child#2	Child #3	Chiropractor's Comments
Smoke?	Y	Y	Y	Y	Y	_____
Drink	Y	Y	Y	Y	Y	_____
Diet (do you eat healthy foods?)	Y	Y	Y	Y	Y	_____
Have you been in accidents?	Y	Y	Y	Y	Y	_____
Have you had surgery						_____

and organs replaced/removed?	Y	Y	Y	Y	Y	_____
Drugs? (Prescriptive or Non-Prescriptive)	Y	Y	Y	Y	Y	_____
Have Teeth Problems?	Y	Y	Y	Y	Y	_____
Have Eye Problems?	Y	Y	Y	Y	Y	_____
Have Hearing Problems?	Y	Y	Y	Y	Y	_____
Exercise regularly?	Y	Y	Y	Y	Y	_____
Have sleeping problems? (nightmares)?	Y	Y	Y	Y	Y	_____
Have occupational stress?	Y	Y	Y	Y	Y	_____
Have physical stress?	Y	Y	Y	Y	Y	_____
Have mental stress?	Y	Y	Y	Y	Y	_____
Have hobbies/sports injuries?	Y	Y	Y	Y	Y	_____
Sleeping posture – side–stomach–back	_____	_____	_____	_____	_____	_____

Current Health Condition

Present Complaint (be brief) Reason For Your Visit Today

Major _____

Pain or Problem started on _____

Pains are: Sharp Dull Constant Intermittent

What activities aggravate your condition/pain? _____

What activities lessen your condition/pain? _____

Is condition worse during certain times of the day? _____

Is this condition interfering with work? _____ Sleep? _____ Routine? _____ Other? _____

Is this condition getting progressively worse? _____

Other Doctors seen for this condition _____

Any home remedies? _____

Other symptoms:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Feet Cold |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Hands Cold |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Ears Ring | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Fever | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Fainting | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Buzzing in Ear |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Loss of Smell | |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of Taste | |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Depression | <input type="checkbox"/> Diarrhea | |

Have you been under drug and medical care? _____

What medications are you taking? _____

How Long? _____ Have you had surgery? _____ What? _____ When? _____

What side effects have you experienced from the drugs and surgery? _____

Is there a family history of:

	Heart Disease	Arthritis	Cancer	Diabetes	Other _____
Father's Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother's Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Upon the completion of your first visit, you will receive a Chiropractic Report to discuss the different types of Active Life Plans that are available to you. Chiropractic Active Life Plans are designed to help get you feeling better quickly and to help you and your family be as healthy as possible. Please review the explanations of the Chiropractic Active Life Plans prior to your Chiropractic Report appointment so you can choose the level of participation that supports you in reaching all of your health goals.

As a result of my chiropractic care, I would like to

Please check all that apply

- | | |
|---|---|
| <input type="checkbox"/> Feel better quickly | <input type="checkbox"/> Have a healthier body by keeping my nerve system healthy |
| <input type="checkbox"/> Have a healthier spine | <input type="checkbox"/> Live a healthier lifestyle |

Signature

Date

Welcome To Pruitt
Chiropractic

Thank you for choosing our office for chiropractic care. We are committed to providing your family with the highest quality of chiropractic care available. We will be working together toward helping you reach your health and wellness goals.

If you ever have any questions about your chiropractic care, please do not hesitate to ask one of our highly educated and committed staff members. All of your questions, even the ones you never thought of asking, will be answered during your Report of Findings and your Human Potential Program.

The following forms are necessary for us to serve you best. Just do your best to fill them out.

We look forward to a long, healthy relationship with you and your family.

Sincerely,
Dr. Craig Pruitt

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method so that we will be able to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

-Dorland's Medical Dictionary

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

(signature)

(date)

Service

Charges

Consultation	No Charge
Initial Exam with Adjustment	\$85
Initial Exam without Adjustment	\$45
Dynamic Exam	\$45
Adjustment	\$40
Active Living Plans	Based on individual recommendations
Corrective Adjustment Plans	Based on individual recommendations

Financial Policy

We are committed to providing you the best chiropractic care possible and have established our financial policies to achieve that goal. You will be expected to pay for your chiropractic care at the time service is rendered unless other arrangements are made in advance. Other arrangements include our yearly Active Living Plans and Corrective Adjustment Plans (CAP). Details of these plans will be discussed with you when the doctor goes over your recommendations to get your spine and nerve system as healthy as possible. Payment's can be scheduled yearly, monthly or by the visit.

____ **Health Insurance:** If we are providers for your insurance plan, and you have chiropractic benefits we will file the insurance for you. If you have insurance that covers chiropractic, and we are not a provider for that plan, we will give you all the information you need to get reimbursed quickly. This includes your diagnosis, prognosis, and copies of your records or reports. We have found it easier for your record keeping and ours if we give you receipts at the end of your first visit and then once per month after that. Just send in your receipts with a copy of your claim form and your insurance company will communicate with you about your reimbursement.

If you are like most of our patients and choose to do a CAP plan, there is a possibility that we may file your insurance for you if we are not a provider for that insurance. We will discuss this option with you at your Report of Findings.

I have read and understand the above policy.

Patient Signature

Date