Date: ___/___/______

Pregnancy Intake Form

Name____ Gender: Male/Female
Preferred Name/Nickname____________________________ Date of Birth____/_____/_____ Age______
Address____City_______________________State_______Zip_______
Parent/Guardian(s) if minor: ____
Primary Phone ____________________ Cell/Home/Work Secondary Phone ___________________ Cell/Home/Work
Email Address __________________________________
Occupation ______________________________________ Employer _________________________________
Single / Married / Divorced / Widowed / Minor Spouse's/Significant Other Name ________________________
Number of Children (or siblings if minor)______ Names, Ages, & Gender _____________________________________
____
Who may we thank for referring you?____

Emergency Contact

Please list the name of someone we can call in case of emergency – if your primary emergency contact (i.e. spouse or parent/guardian) is already receiving care at True North we will attempt to call them first but would like a secondary in the event we are unable to reach them.

Name of emergency contact: ____
Relationship of contact to you: ____
Phone number(s) for contact: ____
Preferred Hospital: GUNDERSEN MAYO OTHER:_______________________

Pregnancy Information

Estimated Due Date: __________________ **# of weeks currently pregnant: ________**

As a result of this pregnancy, have you experienced:
□ Low Back Pain □ Pubic Symphysis Discomfort □ Pelvic/Hip discomfort □ Headache/neck pain
□ Morning sickness □ Gestational Diabetes □ Use of infertility drugs/In-Vitro Fertilization
□ In-Utero Constraint □ Pre-Eclampsia □ Other____

# of Previous Pregnancies: Vaginal ________ C-Section _________ Miscarriage ___________

Please tell us about any complications if any, you experienced in previous pregnancies: ________________________
____
____

Have you received any vaccines while pregnant? □ Yes □ No If yes, which? _____________________________
____

Are you currently taking any medications? □ Yes □ No If yes, which? _____________________________
____

Are you taking any supplements and/or vitamins? □ Yes □ No If yes, what product(s)? ___________________
____

Name: ______________________________ Date: ___/___/_____

Have you taken, or will you take any birth classes?

◻ Bradley ◻ Hypnobabies/Hypnobirthing ◻ BabySteps ◻ Hospital class ◻ Not yet sure
◻ None ◻ Other: ____________________________________

Where do you plan to give birth? ◻ Home ◻ Birth Center ◻ Hospital

If hospital or birth center, which one? ____

Do you plan to use an Obstetrician? ◻ Yes ◻ No
Do you plan to use a Midwife? ◻ Yes ◻ No
Do you plan to use Doula? ◻ Yes ◻ No

Name of OB/Midwife: ____
Practice Name: ____ Phone: __________________________

Name of Doula: ____
Practice Name: ____ Phone: __________________________

May we have your permission to contact your birth attendant and doula to confer with them and share information regarding the chiropractic care that you are receiving here? ◻ Yes ◻ No

What are your hopes or intentions for the birth?

◻ Natural birth ◻ Epidural only if necessary ◻ Definite Epidural ◻ VBAC
◻ Planned Induction ◻ Planned C-Section ◻ Unsure
◻ Other ____

What is your biggest fear going into this birth? ____
____

Please circle topics that you would like to learn more about:

Doulas	Creating a Birth Plan	Chiropractic care for infants	Breast Feeding
Home Birth	Birthing Classes	Vaccination Information	Common Infant Ailments

Other ____

Is there anything else you would like to tell us about your pregnancy or birth? ___________________________________
____
____
____

Name: ______________________________ Date: ___/___/_____

List the Main Health Concerns that Brought You into this Office

1) ______________________ 2) ______________________ 3) ______________________ 4) ______________________

Are there any open auto or workman's compensation claims relating to these main concerns? □ Yes □ No

Please Check Any Issues You Have Had in the Past or Currently Have

___ Neck Pain	___ Scoliosis	___ Hearing Loss	___ High/Low Blood Pressure
___ Shoulder Pain	___ Jaw/TMJ Pain	___ Ringing in the Ears	___ Nausea
___ Arm Pain	___ Headaches/Migraines	___ Dizziness	___ Digestive Issues
___ Back Pain	___ Frequent Colds/Ear Infections	___ Loss of Balance	___ GERD/Gastric Reflux
___ Sciatica	___ Sinus Issues	___ Epilepsy/Seizures	___ Diabetes
___ Hip/Leg Pain	___ Allergies	___ Stroke	___ Kidney Problems
___ Knee Pain	___ ADD/ADHD	___ Tremors	___ Bladder Problems
___ Foot Pain	___ Thyroid Issues	___ Asthma	___ Bedwetting
___ Numb/Tingling in extremities	___ Loss of Energy	___ Sleep Apnea	___ Menstrual Problems
___ Tight/Sore Muscles	___ Sleep Problems	___ Chest Pain	___ Prostate Problems
___ Fibromyalgia	___ Anxiety/Nervousness	___ Difficulty Breathing	___ Sexual Dysfunction
___ Poor Posture	___ Depression	___ Heart Problems	___ Infertility
___ Arthritis/Joint Pain	___ Double/Blurry Vision	___ Heart Attack	___ Cancer

Other health concerns, conditions, or issues you would like us to know or elaborate on from above:

____

____

____

Health History

List any surgical operations & years:

____

____

List any other injuries to your spine, minor or major, that the doctor should know about:

____

Have you ever fractured or broken a bone? □ Yes □ No

If yes, please describe: ____

Other major traumas:____

____

List all over-the-counter & prescription medications you are on and the reason for each:

____

____

____

Name: _______________________________ Date: ___/___/_____

Notice of Privacy Practices Acknowledgement (HIPAA)

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physician's certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

Signature ____ Date: _______________
(Parent Guardian if under 18)

Informed Consent for Chiropractic Care

Chiropractic care, like all forms of health care, while offering considerable benefits may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases, injury has been associated with Chiropractic care. The types of complications that have been reported secondary to Chiropractic care include: sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with Chiropractic care occurring at a rate between one instance per one million to one instance per two million cervical spine (neck) adjustments may be a vertebral injury that could lead to a stroke.

Prior to receiving Chiropractic care in the Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific conditions, your overall health and in particular your spinal health. These procedures will assist us in determining if Chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

- I understand and accept that there are risks associated with Chiropractic care and give consent to the examination that the Doctor deems necessary and the Chiropractic care, including spinal adjustments, as reported following my assessment.
- I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the practice member. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.
- *If forms are for a minor:* I authorize the doctors and any and all True North Chiropractic team members to perform diagnostic procedures, radiographic evaluations, render Chiropractic care and perform Chiropractic adjustments to my minor/child. As of this date, I have the legal right to select and authorize health care services for my minor/child without the permission of a spouse/former spouse or other guardian. If my authority to select and authorize care is revoked or altered, I will immediately notify True North Chiropractic.

Signature ____ Date: _______________
(Parent Guardian if under 18)