VERITY • HEALTH CHIROPRACTIC FAMILY WELLNESS

Pregnancy Health Record

ABOUT YOU

NAME:	
ADDRESS:	
CITY:	STATE/ZIP CODE:
HOME PHONE:	CELL PHONE:
EMAIL ADDRESS:	
DATE OF BIRTH:	AGE:
MARITAL STATUS:	GENDER:
NUMBER OF CHILDREN & AGES:	
EMPLOYER NAME:	
WORK PHONE:	POSITION TITLE:
LAST 4 OF SOCIAL SECURITY:	

ABOUT YOUR SPOUSE

SPOUSE NAME:
SPOUSE EMPLOYER:
POSITION TITLE:

HEALTH HABITS

DO YOU SMOKE? ❑ YES # PACK/DAY ❑ NO

DO YOU DRINK ALCOHOL? ❑ YES # DRINKS/MONTH ❑ NO

DO YOU DRINK COFFEE, TEA OR SODA? ❑ YES # CUPS/DAY ❑ NO

DO YOU EXERCISE REGULARLY? ❑ YES # DAYS/WEEK ❑ NO

DO YOU EAT FAST FOOD? ❑ YES # OF MEALS/WEEK_____ ❑ NO

ARE YOU AWARE OF THE EFFECTS OF YOUR DIET ON YOUR OVERALL HEALTH? ❑ YES ❑ NO

WOULD YOU LIKE MORE INFORMATION ON THE EFFECTS OF DIET ON YOUR HEALTH? ❑ YES ❑ NO

DO YOU SLEEP WELL? ❑ YES ❑ NO # OF HOURS/DAY_____

HOW DO YOU SLEEP? ❑ BACK ❑ SIDE ❑ STOMACH

DO YOU WEAR:

❑ HEEL LIFTS ❑ SOLE LIFTS ❑ INNER SOLES ❑ ARCH SUPPORTS

CHIROPRACTIC HISTORY

WHO May We Thank For Your Referral?

HAVE YOU SEEN OR HEARD OF OUR OFFICE BECAUSE OF (✓ALL THAT APPLY):
❑ NEWSPAPER ❑ SIGN ❑ SOCIAL MEDIA ❑ COMMUNITY EVENT ❑ MAILING

HAVE YOU BEEN CHECKED FOR VERTEBRAL SUBLUXATION?
❑ YES ❑ NO ❑ I DON'T KNOW

HAVE YOU BEEN ADJUSTED BY A CHIROPRACTOR BEFORE?
❑ YES ❑ NO

IF YES, WHAT WAS THE REASON FOR THOSE VISITS?

DOCTOR'S NAME & APPROXIMATE DATE OF YOUR LAST VISIT:

HAS ANY MEMBER OF YOUR FAMILY EVER SEEN A CHIROPRACTOR?

REASON FOR THIS VISIT

REASON FOR THIS VISIT: ❑ WELLNESS ❑ PAIN COMPLAINT
❑ AUTO/JOB INJURY ❑ NUTRITION

PLEASE DESCRIBE:

WHAT DATE DID THIS BEGIN?

DID THIS PROBLEM START:
❑ SUDDENLY ❑ GRADUALLY ❑ AFTER AN INJURY

HAS THIS CONCERN:
❑ GOTTEN WORSE ❑ BECOME CONSTANT/CHRONIC ❑ GOTTEN BETTER
❑ COME AND GONE

WHAT MAKES THE PROBLEM BETTER?

WHAT MAKES THE PROBLEM WORSE?

DOES THIS CONCERN INTERFERE WITH:
❑ WORK ❑ SLEEP ❑ DAILY ROUTINE ❑ OTHER ACTIVITIES
PLEASE EXPLAIN:

PLEASE DESCRIBE THE QUALITY OF THE PAIN (SHARP, DULLY ACHY, ETC.)

DOES THE PAIN RADIATE? ❑ YES ❑ NO
TO WHERE?

RATE THE SEVERITY OF THE PAIN (0=NO PAIN, 10=E.R. VISIT):

DOES THE PAIN CHANGE THROUGHOUT THE DAY? ❑ YES ❑ NO
PLEASE EXPLAIN:

HAVE YOU SEEN OTHER DOCTORS FOR THIS COMPLAINT? ❑ YES ❑ NO
DOCTOR'S NAME:

TYPE OF TREATMENT:

RESULTS: ❑ GOOD ❑ BAD ❑ INDIFFERENT

Verity Health Center
North 850-320-6158 Midtown 850-765-6038

"The doors we open and close each day decide the lives we live."

CHIROPRACTIC KNOWLEDGE

ARE YOU AWARE THAT NOT ALL CHIROPRACTIC CARE IS THE SAME AND NOT EVERY CHIROPRACTIC APPROACH IS SPECIFIC? ❑ YES ❑ NO

ARE YOU AWARE THE CHIROPRACTORS WORK WITH THE NERVOUS SYSTEM?
❑ YES ❑ NO

ARE YOU AWARE THAT THE NERVOUS SYSTEM CONTROLS AND COORDINATES ALL BODY SYSTEMS AND FUNCTIONS?
❑ YES ❑ NO

ARE YOU AWARE THAT SYMPTOMSOFTEN TIMES ARE THE LAST TO SHOW UP?
❑ YES ❑ NO

DID YOU KNOW THAT YOU CAN HAVE LOSS OF FUNCTION WITHOUT EXPERIENCING PAIN?
❑ YES ❑ NO

DID YOU KNOW THAT CHIROPRACTIC CARE IS SAFE DURING PREGNANCY AND CAN HELP TO KEEP THE BABY IN OPTIMAL POSITION FOR LABOR AND DELIVERY?
❑ YES ❑ NO

DID YOU KNOW THAT CHIROPRACTIC CARE CAN HELP CHILDREN FUNCTION OPTIMALLY TOO?
❑ YES ❑ NO

GOALS FOR YOUR CARE

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their body. Your Doctor will weigh your needs and desires when recommending your care program. Please check the type of care desired so that we may be guided by your wishes whenever possible. PLEASE PICK ONE.

- ❑ **As Needed:** Symptomatic relief of pain or discomfort.
- ❑ **Corrective Care:** Correcting and relieving the cause of the problem as well as the symptom or pain.
- ❑ **Maintenance/ Wellness:** Prevent future problems from occurring and old ones from returning.
- ❑ ***I want the Doctor to select the type of care for my condition.***

PERSONAL HISTORY

DO YOU HAVE ANY DIAGNOSED DISEASES (HEART DISEASE, DIABETES, ETC.)? ? ❑ YES ❑ NO
PLEASE LIST:

DO YOU HAVE A HISTORY OF CAR ACCIDENTS, BROKEN BONES, FALLS OR OTHER TRAUMAS? ❑ YES ❑ NO
PLEASE LIST:

HAVE YOU HAD ANY SURGERIES? ❑ YES ❑ NO
PLEASE LIST WITH APPROXIMATE DATES:

ARE YOU CURRENTLY EXPERIENCING ANY MAJOR STRESS IN YOUR LIFE OTHERWISE UNLISTED ON THIS FORM? ❑ YES ❑ NO

Many problems and health challenges can start as 'nerve interference' blocking the vital power that operates and heals our body. Please CIRCLE below any concerns you are experiencing now as well as in the past. Feel free to list any other concerns or health challenges you may be having under 'other'.

OTHER SYMPTOMS

Sore Throat
Stiff Neck
Radiating Arm Pain
Hand/Finger Numbness
Asthma
Allergies
High Blood Pressure
Heart Conditions

Headaches
Migraines
Dizziness
Sinus Problems
Allergies
Fatigue
Head Colds
Vision Problems
Difficulty Concentrating
Hearing Problems

Middle Back Pain
Congestion
Difficulty Breathing
Bronchitis
Pneumonia
Gallbladder Conditions
Stomach Problems
Ulcers
Gastritis
Kidney Problems

Constipation
Colitis
Diarrhea
Gas Pain
Irritable Bowel
Bladder Problems
Menstrual Problems
Low Back Pain
Pain or Numbness in legs
Reproductive Problems

OTHER:

_____

_____

_____

FAMILY HISTORY

PLEASE MARK ANY CONDITIONS YOUR FAMILY MEMBERS HAVE BEEN DIAGNOSED WITH:

M = MOTHER F=FATHER S=SIBLINGS G = GRANDPARENTS

CANCER: TYPE_____
❑ M ❑ F ❑ S ❑ G

DEPRESSION
❑ M ❑ F ❑ S ❑ G

DIABETES
❑ M ❑ F ❑ S ❑ G

HEART DISEASE
❑ M ❑ F ❑ S ❑ G

LIVER DISEASE
❑ M ❑ F ❑ S ❑ G

HIGH CHOLESTEROL
❑ M ❑ F ❑ S ❑ G

HIGH BLOOD PRESSURE
❑ M ❑ F ❑ S ❑ G

LUNG PROBLEMS
❑ M ❑ F ❑ S ❑ G

SEIZURES
❑ M ❑ F ❑ S ❑ G

NECK PROBLEMS
❑ M ❑ F ❑ S ❑ G

BACK PROBLEMS
❑ M ❑ F ❑ S ❑ G

SCOLIOSIS
❑ M ❑ F ❑ S ❑ G

OSTEOARTHRITIS
❑ M ❑ F ❑ S ❑ G

RHEUMATOID ARTHRITIS
❑ M ❑ F ❑ S ❑ G

AUTOIMMUNE DISEASES
❑ M ❑ F ❑ S ❑ G

OTHER:_____

ABOUT YOUR PREGNANCY

Is this your first pregnancy? ❑ YES ❑ NO How many pregnancies have you had: __
Any complications with previous pregnancies?

Was this pregnancy planned? ❑ YES ❑ NO
IF YES, HOW FAR ALONG?_____WEEKS
DUE DATE:_____

Who is your primary caregiver? ❑ OBGYN ❑ GP ❑ MIDWIFE NAME:_____
DELIVERY LOCATION? ❑ HOSPITAL ❑ HOME ❑ BIRTHING CENTER ❑ OTHER
ANY SPECIAL BIRTH ARRAINGEMENTS(C-SECTION, WATER BIRTH, ETC.)
PLANNED?

HAVE YOU HAD ANY GENETIC TESTING/? ❑ YES ❑ NO
DATES AND REASONS:_____
DO YOU HAVE BLOOD PRESSURE CONCERNS? ❑ YES ❑ NO
ARE YOU PLANNING TO BREASTFEED? ❑ YES ❑ NO

HAVE YOU NOTICED:
SWELLING IN ARMS AND LEGS ❑ YES ❑ NO
BACK PAIN ❑ YES ❑ NO I F SO WHERE:_____
NECK PAIN ❑ YES ❑ NO DIZZINESS/NASEAU ❑ YES ❑ NO
DIGESTIVE COMPLAINTS ❑ YES ❑ NO
HEARTBURN/CONSTIPATION ❑ YES ❑ NO
HEADACHES ❑ YES ❑ NO
PAIN RADIATING DOWN LEGS ❑ YES ❑ NO
HEART PALPATATIONS ❑ YES ❑ NO
ANY OTHER CONCERNS? _____

PHYSICAL STRESSES

ANY SIGNIFICANT INJURIES IN CHILDHOOD OR ADULTHOOD?

ANY HOSPITAL VISITS ❑ YES ❑ NO

EXPLAIN:_____
ANY SURGERIES? ❑ YES ❑ NO

LIST:_____

ANY FRACTURES OR DISLOCATIONS? ❑ YES ❑ NO
LIST:_____

ARE YOU IN PROLONGEDPOSTURES (EX:SITTING, LIFTING, ETC)

❑ YES ❑ NO EXPLAIN:_____
ANY HOBBIES THAT ARE PHYSICALLY STRENUOUS? ❑ YES ❑ NO

EXPLAIN:_____

WHAT IS YOUR USUAL EXERCISE ROUTINE:

ANY VEHICLE ACCIDENTS? ❑ YES ❑ NO
WHAT HAPPENED AND WHEN?

CHEMICAL STRESSES

ARE YOU TAKING ANY MEDICATIONS? ❑ YES ❑ NO
IF YES LIST BELOW

_____

ARE YOU TAKING ANY SUPPLEMENTS? ❑ YES ❑ NO
IF YES LIST BELOW

_____

DO YOU DRINK BOTTLED WATER? ❑ YES ❑ NO
ARE YOU EXPOSED TO ANY OF THE FOLLOIWNG:
❑ POLLUTANTS ❑ STRONG SMELLS ❑ CHEMICALS ❑ AEROSOLS
DO YOU EAT ORGANIC ❑ YES ❑ NO
DO YOU USE NATURAL/ENVIRONMENTALLY FRIENDLY PRODUCTS?
❑ YES ❑ NO
DO YOU DRINK, BATHE OR SHOWER IN CHLORINATED WATER?
❑ YES ❑ NO

EMOTIONAL STRESSES

RANK FROM 1 (MINIMAL) TO 10 (EXTREME):
LIFE IN GENERAL_____ WORK AND CAREER_____ RELATIONSHIP_____
FINANCES_____ TIME MANAGEMENT_____ THIS PREGNANCY____
HEALTH AND WELL BEING_____ QUALITY OF SLEEP_____ HOBBIES_____

PLEASE LIST ANY SIGNIFICANT OR ONGOING STRESS:

DO YOU PRACTICE ANY FORM OR RELAXATION? ❑ YES ❑ NO
EXPLAIN:

ANY ADDITIONAL CONCERNS:

ARE YOU INTERESTED IN LEARNING STRESS REDUCING PRACTICES?
❑ YES ❑ NO

THANK YOU FOR CHOOSING VERITY HEALTH CENTER AND HELPING US CONTINUE OUR MISSION TO
Help Families Experience True Health!

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives, as well as the risks associated with chiropractic adjustments and all other procedures provided at Verity Health Center, have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ ____/____/____ _____ *Witness Initials*

Patient or Authorized Person's Signature Date

_____ ____/____/____

Doctor's Signature **Date**

NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

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

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

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed. I also allow use of my personal email address for office communication.

To receive text appointment reminders, initial here_____

PATIENT NAME (PLEASE PRINT):	RELATIONSHIP TO PATIENT:
SIGNATURE:	DATE: