New Pregnancy Application

This form is for pregnant mothers only. Please ask the front desk for our new adult or pediatric forms.

Today's Date: ____/____/____ **Age:** _____ **Date of Birth**______/______/______

Name: ______________________________ **Who may we thank for referring you?** ______________________________

Address: ______________________________ **City:** ____________________ **State:** _____ **Zip:** _________

Primary Phone: ______________________________ **Email:** ____

For confirming appointments and important updates do you prefer? TEXT or EMAIL

Occupation: ____________________________ **Company Name:** _______________________________

Please indicate if you or your spouse are a: TEACHER/STUDENT FIRST RESPONDER MILITARY/VETERAN

Single / Married / Divorced / Widowed **Spouse's Name:** ______________________________

Are you currently receiving care from any other health professionals? YES / NO

If yes, who, and what is their specialty? _______________________________________

Have you ever been adjusted before? YES / NO

If yes, how was your experience?

GOOD / BAD / INDIFFERENT

What would you like to gain from chiropractic care?

☐ Pain Relief ☐ Overall Wellness ☐ Both

What are your health goals for your pregnancy?

1. _________________________________
2. _________________________________
3. _________________________________

Previous Birth Experience

Is this your first pregnancy? ☐ YES ☐ NO

If not, please tell us about your previous pregnancy/s and/or birth experience/s. (ie: how many, type of delivery/s, complication/s, etc.) ______________________________

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Conception & Early Pregnancy

When is your expected or calculated due date? ____________

Did you have difficulty conceiving? ☐ YES ☐ NO

If yes, please explain: ______________________________

Have you ever used any form of hormonal or oral contraceptives? ☐ YES ☐ NO

If yes, which ones and for how long? ______________________________

Current Health Status

What types of exercising and/or stretching are you currently performing? ______________________________

Please tell us about your current diet, and any dietary restrictions. ______________________________

Have you taken any medications or supplements during your pregnancy? ☐ YES ☐ NO

If yes, please explain: ______________________________

Have you had any slips, falls, or other physical traumas during the pregnancy? ☐ YES ☐ NO

If yes, please explain: ______________________________

Have you had any major emotional stressors during your pregnancy? ☐ YES ☐ NO

If yes, please explain: ______________________________

Do you have a birth plan? ☐ YES ☐ NO

If yes, please explain: ______________________________

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Are you taking any pre-natal or birthing classes? ☐ YES ☐ NO

If yes, please explain: ______________________________

Do you intend to have a doula or birth coach present? ☐ YES ☐ NO

If yes, please explain: ______________________________

Do you plan on getting adjusted post-birth? ☐ YES ☐ NO

If no, is there any specific reason? ____

Do you plan on getting your newborn adjusted post-birth? ☐ YES ☐ NO

If no, is there any specific reason? ____

Do you plan to breast feed your child? ☐ YES ☐ NO

Are there any concerns or questions you have that you would like the doctor to address or answer?

____

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____

Other than pregnancy please list any additional concerns you may have about your health:

Health Concerns: (List according to severity)	Rate of Severity 1= Mild 10=Unbearable	When did the Symptoms Start?	Are the Symptoms Constant or Intermittent?
1________________	____________	____________	____________
2________________	____________	____________	____________
3________________	____________	____________	____________
4________________	____________	____________	____________
5________________	____________	____________	____________

Reserved for Chiropractic Assistant: (O-PP-Q-R-S-T) Chiropractic Assistant Initials: ______

Onset/Palliative/Provocative/Quality/Radiate/Severity/Time

____

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____

____

____

Past Health Information

Please circle any of the following health conditions that you have experienced:

Stroke, Cancer, Heart Disease, Spinal Surgery, Seizures,

Spinal Bone Fracture, Scoliosis, Diabetes, Infections, Miscarriages

List all surgical operations: ____

When was your last leisure, auto, home, or work accident?

________________/_________________/___________________/_______________/_______________

Have you ever been knocked unconscious? YES / NO Fractured a bone? YES / NO

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Notice of Privacy Practices Acknowledgment

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

1. Conduct, plan, and direct my care 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 care, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I request and authorize Cornerstone Family Chiropractic to release my health information to the following parties:

Name: ____ **Relationship to me:** ______________________

Name: ____ **Relationship to me:** ______________________

Signature ____________________________________ **Date:** _____/_____/_____
(Required)

Terms of Acceptance

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

Our main goal is to help your body (specifically your spine and nervous system) become more mobile, adaptable, and functional. When this is achieved often times you will feel better as a result. It is important that each practice member understand both the objective and the method that will be used to ascertain 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 subluxations. Our chiropractic method of correction is by specific adjustments to the spine or extremities.

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

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.

Our main goals and objectives are to locate and correct vertebral subluxations of the spine. Chiropractic is not designed to make you instantly feel better, rather the chiropractic method is and has always been to improve your body's ability to adapt and cope with both the internal and external stresses. We have laid out clear objective and subjective measures for care. During active care we will actively measure subjective and objective improvement through various ways of measurement. Once discharged from active care you will be given the opportunity to continue with supportive or maintenance care (both supportive and maintenance care are not covered by insurance). At any time during your care with us, if we find unusual finding or are unable to reach any of the subjective or objective goals set, we will provide a referral to a care provider better suited to care for that specific need. We do not offer any other services besides chiropractic care in our office. It is your responsibility to be consistent with the at home instructions that our doctors provide.

FIRST DAY COSTS: You will be responsible to pay in full for all first day costs including co-pays prior to leaving; including but not limited to: evaluations, x-rays, first day adjustments. Unless our office staff has in writing any other arrangement for payment. First day adjustment pricing does differ from adjustment pricing that will be built into your care plan. We will disclose any and all pricing prior to rendering services.

I, ___________________________________ have read & fully understand the above statements.

Print Name

Signature ____ **Date:** _____/_____/_____

(Required)

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, but not limited to: sprain/strain injuries, irritation of a disc condition, fractures. One of the rarest complications associated with chiropractic care occurring at a rate of one instance per one per two million cervical spine (neck) adjustments may be a vertebral injury that could lead to a stroke.

Prior to receiving chiropractic care in this 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 provided to you along with a care plan prior to beginning care.

I understand and accept that there are risks associated with chiropractic care and I give full consent to the examination that the doctor deems necessary and the chiropractic care including: spinal adjustments, therapies, and evaluations as reported following my initial assessment.

If you do not wish to have ANY part of your spine checked and adjusted, please do not sign and notify either one of the chiropractic assistants or the doctor to discuss your concern prior to receiving care.

Print ____

____
Witness Signature (Office Staff)

Signature ____________________________________ **Date:** _____/_____/_____
(Required)

Practice Member Insurance Information

(Must be Completed Before Services Can Be Rendered)

SOCIAL SECURITY NUMBER: ____________________________

CONTACT IN CASE OF EMERGENCY: ________________________

Phone #: _____________________

NAME OF PRIMARY INSURANCE CARRIER:

____

Name of Insured________________________

Date of Birth _________________

Insured Social Security Number _________________

NAME OF SECONDARY INSURANCE CARRIER:

____

Name of Insured________________________

Date of Birth _________________

Insured Social Security Number: _________________

Signed____

Date__________________

Insurance Policies and Fee Schedule

- Consultation- includes practice member history. This service is complimentary
- Assessment (new or established practice member)- includes one or more of the following: thermography, surface electromyography, range of motion, motion and/or static palpation, HRV, leg check $50-$250.
- Chiropractic Adjustment- The actual re-alignment of the vertebra done by hand. Often a sound will be heard, but if there is no auditory result, it does not mean that the adjustment has not taken place. $35-$65.
- X-rays- Specific x-ray views taken of your spine to help determine a misalignment/subluxation of your vertebrae. These can also be used to indicate progress after period of care. $50-$300.

Release of Authorization/Assignment of Benefits

I authorize and request payment of insurance benefits directly to Cornerstone Family Chiropractic. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. 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.