904 Rainbow Drive
Cedar Falls, IA
319-277-1868

PREGNANCY HEALTH HISTORY

Name______________________**Date of Birth**___/____ / ____**Age**_____**Male/Female**

Address_________________________**City**____________________**State** ______________**Zip**____________________

Phone: Cell_____________________**Home** _______________ **Work:** ____________________

Email Address____

Occupation ______________________________**Employer's Name** ____________________

Are you a student? YES NO **Have you ever been in the military? YES NO**

Single / Married / Divorced / Widowed **Spouse's Name**________________________________

Number of Children_______**Names, Ages & Gender** ____________________________________

Who may we thank for referring you? ______________________________________

LIST THE HEALTH CONCERNS THAT BROUGHT YOU INTO THIS OFFICE

Health Concern: List according to severity	Rate of Severity 0 = no pain 10 = unbearable	Did you have this problem prior to pregnancy?	When did this problem start?	Did the problem begin with an injury?	Are symptoms constant (C) or intermittent (I)?
Primary:__________	__________	__________	__________	__________	__________
Second:__________	__________	__________	__________	__________	__________
Third:__________	__________	__________	__________	__________	__________
Fourth:__________	__________	__________	__________	__________	__________

HAVE YOU EVER SEEN OTHER DOCTORS FOR THESE CONDITIONS? YES / NO

CHIROPRACTOR?__________________**MEDICAL DOCTOR?**__________________**OTHER**__________________

WHO AND WHEN? ____

WHAT WERE THE RESULTS? FAVORABLE UNFAVORABLE (please explain) ______________________

PLEASE MARK "P" FOR IN THE PAST, OR MARK "C" FOR CURRENTLY HAVE:

___ *Headaches*	___ *Ear Infections*	___ *Sinus Issues*	___ *Kidney Problems*	___ *Sexual Dysfunction*
___ *Migraines*	___ *Hearing Loss*	___ *Frequent Colds*	___ *Bladder Problems*	___ *Sleep Problems*
___ *Jaw/TMJ Pain*	___ *Ringing in the Ears*	___ *Thyroid Issues*	___ *Menstrual Problems*	___ *Tight/Sore Muscles*
___ *Neck Pain*	___ *Dizziness*	___ *Asthma*	___ *Prostate Problems*	___ *Sports Injury*
___ *Shoulder Pain*	___ *Loss of Energy*	___ *Chest Pain*	___ *Infertility*	___ *Sciatica*
___ *Arm Pain*	___ *Nervousness*	___ *Heart Problems*	___ *Fibromyalgia*	___ *Arthritis/Joint Pain*
___ *Upper Back Pain*	___ *Double/Blurry Vision*	___ *Nausea/Vomiting*	___ *Epilepsy/Convulsions*	___ *GERD/Gastric Reflux*
___ *Mid Back Pain*	___ *Anxiety*	___ *Ulcers*	___ *Tremors*	___ *Numb/Tingling in Arms/Hands*
___ *Lower Back Pain*	___ *ADD/ADHD*	___ *Digestive Issues*	___ *Disc Problems*	___ *Numb/Tingling in Legs/Feet*
___ *Hip/Leg Pain*	___ *Loss of Balance*	___ *Diarrhea*	_ *Scoliosis*	___ *Stomach Problems*
___ *Knee Pain*	___ *Depression*	___ *Constipation*	___ *Poor Posture*	___ *High/Low Blood Pressure*
___ *Foot Pain*	___ *Allergies*	___ *Bed Wetting*	_ *Skin Problems*	___ *Difficulty Breathing*

*Other:*____

PLEASE MARK "P" FOR IN THE PAST, OR MARK "C" FOR CURRENTLY HAVE:

___STROKE ____CANCER _HEART ATTACK ___SPINAL SURGERY_____SEIZURES ___SPINAL BONE FRACTURE ___SCOLIOSIS
___DIABETES ___OSTEOARTHRITIS ___RHEUMATOID ARTHRITIS ___OTHER CONDITIONS/DISEASES

LIST ALL SURGICAL OPERATIONS AND YEARS: ____________________

LIST ANY OTHER INJURIES TO YOUR SPINE, MINOR OR MAJOR, THAT THE DOCTOR SHOULD KNOW ABOUT:

____

LIST ALL OVER THE COUNTER & PRESCRIPTION MEDICATIONS YOU ARE ON: ____________________

____

WHEN WAS YOUR LAST AUTO ACCIDENT?____________________

HAVE YOU EVER BEEN KNOCKED UNCONSCIOUS? YES/NO FRACTURED A BONE? YES/NO

IF YES TO EITHER OF THE ABOVE, PLEASE DESCRIBE:____________________

OTHER TRAUMA:____________________

____

Since physiological stress has been shown to affect numerous systems and fetal function, please let us know how you are coping with life's stresses. Rank 1 to 10 (1=very poorly and 10=perfectly)

Life in general I feel ______
Financial stress I feel ______
Health and well-being I feel ________________________

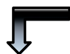
Work and career I feel ______
Time management I feel ______
Quality of sleep I feel ______

Relationships I feel ______
Sports and hobbies I feel ______
About my pregnancy I feel ______

IF YOU HAVE SIGNIFICANT OR ONGOING STRESS, PLEASE EXPLAIN: ____________________

DO YOU PRACTICE SOME FORM OF MEDITATION, BREATH WORK OTHER MIND-BODY MOVEMENT OR HAVE A ROUTINE TO REDUCE YOUR STRESS? YES / NO EXPLAIN: ____________________

WHAT IS YOUR USUAL EXERCISE ROUTINE? ____________________



List Your Current Health Goals Below

HEALTH GOAL	DATE TO ACCOMPLISH	SIGNIFICANCE OF GOAL
Ex: Get rid of my headaches	1/1/2016	I want to play with my kids without pain, be able to spend more time with my family and have more energy.
1.______	______	______
2.______	______	______
3.______	______	______

About Your Pregnancy

What is the estimated date of delivery? ____

Is this your first pregnancy? YES / NO

If not, how many times have you been pregnant? ________________________________

Have you had any complications with previous pregnancies? YES / NO (if yes, please explain):

____

If you have had any miscarriage(s), how far along in your pregnancy did it occur? ________________

Was this pregnancy planned? YES / NO

Who is your primary caregiver for delivery? OBGYN / GP / Midwife Name: __________________

What is your planned location for delivery? HOSPITAL / HOME / BIRTHING CLINIC / OTHER

How do you feel about this pregnancy? ____

Do you have a birth plan? YES / NO

Would you like information on creating one? YES / NO

Any special arrangements for birth? (Planned C-section, water delivery, birth chair, squat, etc): ______________

Have you had any testing? (Genetic, blood, ultrasound, amniocentesis, chorionic vili sampling, other)? __________

Dates and reasons: ____

Are you planning on breastfeeding post-delivery? YES / NO

Would you like further information on the advantages of breastfeeding? YES / NO

Was your blood pressure prior to pregnancy: NORMAL / LOW / HIGH

What is your current blood pressure and when was it last checked? _________________________

Have you changed your diet since learning of your pregnancy? YES / NO

Have you smoked prior to or along with this pregnancy? YES / NO / QUIT

Have you had alcohol during this pregnancy? YES / NO

Are you currently taking any supplements? YES / NO If yes, which ones? ____________________

Do you drink bottled water? YES / NO

Do you eat organic? YES / NO

Are you exposed to pollutants, chemicals, aerosols, etc? YES / NO / OCCASIONALLY

Do you use natural or environmentally friendly products at home? YES / NO / OCCASIONALLY

Do you drink or bathe/shower in chlorinated water? YES / NO

ACTIVITIES OF DAILY LIVING

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITY:	**EFFECT:**			
Carrying Groceries	☐ **No Effect**	☐ **Painful (can do)**	☐ **Painful (limits)**	☐ **Unable to Perform**
Sit to Stand	☐ **No Effect**	☐ **Painful (can do)**	☐ **Painful (limits)**	☐ **Unable to Perform**
Climbing Stairs	☐ **No Effect**	☐ **Painful (can do)**	☐ **Painful (limits)**	☐ **Unable to Perform**
Pet Care	☐ **No Effect**	☐ **Painful (can do)**	☐ **Painful (limits)**	☐ **Unable to Perform**
Driving	☐ **No Effect**	☐ **Painful (can do)**	☐ **Painful (limits)**	☐ **Unable to Perform**
Extended Computer Use	☐ **No Effect**	☐ **Painful (can do)**	☐ **Painful (limits)**	☐ **Unable to Perform**
Household Chores	☐ **No Effect**	☐ **Painful (can do)**	☐ **Painful (limits)**	☐ **Unable to Perform**
Lifting Children	☐ **No Effect**	☐ **Painful (can do)**	☐ **Painful (limits)**	☐ **Unable to Perform**
Dressing	☐ **No Effect**	☐ **Painful (can do)**	☐ **Painful (limits)**	☐ **Unable to Perform**
Shaving	☐ **No Effect**	☐ **Painful (can do)**	☐ **Painful (limits)**	☐ **Unable to Perform**
Sexual Activities	☐ **No Effect**	☐ **Painful (can do)**	☐ **Painful (limits)**	☐ **Unable to Perform**
Sleep	☐ **No Effect**	☐ **Painful (can do)**	☐ **Painful (limits)**	☐ **Unable to Perform**
Static Sitting	☐ **No Effect**	☐ **Painful (can do)**	☐ **Painful (limits)**	☐ **Unable to Perform**
Static Standing	☐ **No Effect**	☐ **Painful (can do)**	☐ **Painful (limits)**	☐ **Unable to Perform**
Walking	☐ **No Effect**	☐ **Painful (can do)**	☐ **Painful (limits)**	☐ **Unable to Perform**
Washing/Bathing	☐ **No Effect**	☐ **Painful (can do)**	☐ **Painful (limits)**	☐ **Unable to Perform**
Sweeping/Vacuuming	☐ **No Effect**	☐ **Painful (can do)**	☐ **Painful (limits)**	☐ **Unable to Perform**
Dishes	☐ **No Effect**	☐ **Painful (can do)**	☐ **Painful (limits)**	☐ **Unable to Perform**
Laundry	☐ **No Effect**	☐ **Painful (can do)**	☐ **Painful (limits)**	☐ **Unable to Perform**
Yard work	☐ **No Effect**	☐ **Painful (can do)**	☐ **Painful (limits)**	☐ **Unable to Perform**
Garbage	☐ **No Effect**	☐ **Painful (can do)**	☐ **Painful (limits)**	☐ **Unable to Perform**
Concentration (Reading)	☐ **No Effect**	☐ **Painful (can do)**	☐ **Painful (limits)**	☐ **Unable to Perform**
Other: ____________	☐ **No Effect**	☐ **Painful (can do)**	☐ **Painful (limits)**	☐ **Unable to Perform**
Other: ____________	☐ **No Effect**	☐ **Painful (can do)**	☐ **Painful (limits)**	☐ **Unable to Perform**

Signature:____Date____/_____/______

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 OCURRING AT A RATE BETWEEN ONE INSTANCE PER ONE MILLION TO 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 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.

____
PRINT PRACTICE MEMBERS NAME HERE

____ ____________________
PRACTICE MEMBER'S SIGNATURE OR GUARDIAN SIGNATURE **DATE**

IF THIS HEALTH PROFILE IS FOR A MINOR/CHILD, PLEASE FILL OUT AND SIGN BELOW

WRITTEN CONSENT FOR A CHILD

NAME OF PRACTICE MEMBER WHO IS A MINOR/CHILD ________________________________

I AUTHORIZE DR. ABBY AND ANY AND ALL RADIANCE CHIROPRACTIC STAFF 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. IF MY AUTHORITY TO SELECT AND AUTHORIZE CARE IS REVOKED OR ALTERED, I WILL IMMEDIATELY NOTIFY RADIANCE CHIROPRACTIC.

____________________ ________________________________
DATE GUARDIAN SIGNATURE **AND** RELATIONSHIP TO MINOR/CHILD

__________________________ ____________________
WITNESS SIGNATURE (OFFICE STAFF) **DATE**

TERMS OF ACCEPTANCE

In order to provide for the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-practice member relationship, it is our wish to provide each practice member with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following point regarding chiropractic care and the services that are offered through this clinic:

A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine.
B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from normal spinal structures and configurations that interfere with normal nerve process.
C. The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one million times each day by doctors of chiropractic in the United States alone.
D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of need.
E. Chiropractic does not seek to replace or compete with your medical, dental, or other type(s) of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
F. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health through chiropractic.
G. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration, or cost, in what we work to maintain as a supporting, open environment.

- By my signature below, 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 satisfaction. I therefore accept chiropractic care on this basis.

______________________________ ____________________

(Signature) **(Date)**

Notice of Privacy Practices Acknowledgement

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

1. toC:onduct, 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)**

FAMILY HEALTH HISTORY

THIS FORM IS TO ASSIST THE DOCTORS BY PROVIDING PAST HEALTH HISTORY INFORMATION FOR THEIR REVIEW.

PLEASE PRINT YOUR NAME HERE ______________________ DATE ______________

CONDITION	SPOUSE	SON	DAUGHTER	MOTHER	FATHER
HEADACHES					
NECK PAIN					
JAW/TMJ PAIN					
SHOULDER PAIN					
BACK PAIN					
HIP/LEG PAIN					
ARTHRITIS/JOINT PAIN					
EAR INFECTIONS					
HEARING LOSS					
DIZZINESS					
LOSS OF ENERGY					
NERVOUSNESS					
BLURRED/DOUBLE VISION					
ANXIETY					
ADD/ADHD					
DEPRESSION					
ALLERGIES					
SINUS ISSUES					
THYROID PROBLEMS					
ASTHMA					
BREATHING PROBLEMS					
HEART PROBLEMS					
HIGH/LOW BLOOD PRESSURE					
STOMACH PROBLEMS					
BED WETTING					
INFERTILITY					
SCIATICA					
FIBROMYALGIA					
POOR POSTURE					
SLEEP PROBLEMS					
STROKE					
CANCER					
HEART DISEASE					
DIABETES					
ARTHRITIS					
ALZHEIMERS					