Pregnancy Health Questionnaire

Welcome to Adjusting the World Chiropractic

Name:_____Date:_____

*Please make sure you have completed the **Patient Online Intake form from our website**. The following pages are designed to give us further information about your health and lifestyle, which will allow us to better serve you. It also includes forms requiring signatures, including privacy (HIPAA), our financial policy, and informed consent for treatment. Thank you and we look forward to serving you!*

Wellness Profile

Throughout the exam, the doctor will be searching for one thing: the CAUSE of your health challenge. Chiropractic wellness care seeks to find the causes of a health challenge, rather than simply trying to artificially alleviate the symptoms. The following questions are vital to finding the cause of your current health condition and finding solutions to your health challenge. It is important to investigate the types of stresses to know where your body is accumulating stress, which decreases your body's ability to perform at an optimal level. Please take your time answering these questions, including anything that you may feel is related to your current complaints.

Physical

Describe your birth process: Long Delivery Cesarean Forceps Vacuum Breech Induction Epidural

Circle any experiences as a child/teen:

Fall out of Bed
Childhood sicknesses: (please list)
_____
Growing Pains
Child Abuse
Fall down the Stairs
Yanked by the Arm
Fall off your bike/out of tree, etc.

Rate the following on a scale 1-10 (10 being Excellent):

Exercise: _____ When and what? _____
Posture: _____
Sleep: _____ Hours per day? _____Position_____

Do you stretch regularly?	**Yes**	**No**
Do you do cardio regularly?	**Yes**	**No**
Do you do strength training regularly?	**Yes**	**No**
Do you change your workout routine?	**Yes**	**No**
Belong to health club?	**Yes**	**No**

How do you spend the majority of your day? Seated Standing Other: _____

Do/did you play sports? **Yes No** **What do/did you play?** _____

Biochemical

Were you vaccinated as a child?	**Yes**	**No**
Were you on medications as a child?	**Yes**	**No**
Drink Bottled water?	**Yes**	**No**
Drink Soda? (Diet or Regular)	**Yes**	**No**
Do you have an air purifier?	**Yes**	**No**

Are you exposed to any of the following (circle):

artificial sweeteners	refined sugar
antiperspirant	medications
cleaning chemicals	nutritional deficiencies
microwaved foods	processed foods
fast foods	fatty foods

How many servings does your child have per day: **Fruits? ____ Vegetables? _____ Meat? _____ Dairy? _____**
How frequently do you eat per day? **1-2 meals 3-4 meals 5-6 meals snack all day**

Emotional

What do you do for stress relief? _____
What causes you the most stress? _____

Rate the following on a scale of 1-10 (10 being Best):

Your stress level: Personal: _____
Occupational: _____
Daily Positive Thoughts: _____
Taking time for you: _____
Doing things you love: _____

Have you experienced: (Approx. Date)

Loss of a loved one: _____
Experienced Divorce: _____
Had a serious illness/pain: _____
Been Depressed: _____
Suffered from Anxiety: _____

Family

At our office we are not only interested in your health and wellbeing but also that of your family and loved ones.
Please mention below any **health conditions or concerns** you may have about your:

Children: _____ **Spouse:** _____
Mother: _____ **Father:** _____
Brother(s): _____ **Sister(s):** _____

Pregnancy Specific Questions

Pregnancy Specific Questions

How many weeks pregnant are you? _____ Due Date: _____ BOY GIRL UNSURE
How many pregnancies have you had? _____ Miscarriages? _____ Abortions? _____
Have you had any traumas (accidents, falls) during this pregnancy? If yes, please describe:
_____
Please list any medications taken during this pregnancy:
_____
Have you ever had surgery in the genital region? ____ If yes, describe: _____
Any history of large babies in your or the baby's father's family or in previous pregnancies? ❑ Yes ❑ No
Do you smoke or drink alcohol? ❑ Yes ❑ No
Do you have a birth plan? ❑ Yes ❑ No Would you like help with one? ❑ Yes ❑ No
Will your birth be (circle): with a midwife with an OB at home at hospital birthing center undecided
Which location do you plan on delivering? _____
Are you OK with the use of the following (circle): epidural Pitocin vaccinations at birth ultrasounds
How many ultrasounds have you had? _____

Pregnancy Emotions

How did you feel when you found out you were pregnant? _____
What is your current living situation? (I.e. Married, Single, other children at home, smokers)
_____
What are your most significant fears associated with this birth? _____
_____
_____
Rate your stress on a scale of 1-10 _____

Previous Birth History (if multiple, please answer questions considering all previous experiences)

❑No previous birth history (skip this section)
Previous births: _____
Place of birth: _____ Delivering Practitioner (circle): OB/GYN Midwife
Position of delivery: on back w/ feet up on side kneeling squatting other
Was labor induced? If yes, what type _____
Were your membranes ruptured by your provider? ❑ Yes ❑ No
Did you receive pain medications/anesthesia? If yes, what type _____
Did you delivery vaginally? ❑ Yes ❑ No
What was the presentation of the baby at the time of delivery? Normal Posterior Breech Facial Brow
Were operative devices used at birth? ❑ Yes ❑ No If yes, (circle) forceps vacuum
Was there injury to the baby? ❑ Yes ❑ No

I consent to a professional and complete chiropractic examination and I refuse any radiographic examination due to my pregnancy. I understand that any fee for service rendered is due at the time of service.

Signature _____ Date: _____

Financial Policy

IN–NETWORK GROUP OR INDIVIDUAL INSURANCE

Your insurance is an agreement between you and your insurance company, not between your insurance company and our office. We cannot be certain if your insurance covers Chiropractic, although most policies do provide coverage. The amount they pay varies from one policy to another. We will call to verify your benefits; however, the benefit quote obtained from your insurance company is not a guarantee of payment. As a courtesy to you, our office will complete any necessary insurance forms at no additional charge, and file them with your insurance company to help you collect. It is to be understood and agreed that any services rendered are charged to you directly and you are personally responsible for payment of any non-covered services, deductibles, co-insurance or co-pays. You portion of charges are immediately due upon processing by insurance. **We will provide you with a monthly statement however we strongly encourage you to pay your anticipated amount due by the end of every week to avoid past due balances and interest charges.**

PATIENTS WITH OUT OF NETWORK INSURANCE

If you have insurance coverage with a company that we are not currently in network with we will attempt to verify you insurance and share the information with you during your report of findings on your 2nd visit. As a courtesy we will submit your claims; however we do not accept assignment with all insurance companies. We will let you know if we can accept assignment for you. When assignment is accepted the reimbursement will be sent directly to our office and you will only be asked to pay your anticipated patient portion and then any remainder amount due after insurance is complete. If we do not accept assignment, insurance reimbursement will be sent to you and your account will be handled in our office as a Cash account. Please see: "CASH PAYING…"

PERSONAL INJURY, AUTOMOBILE ACCIDENTS & WORKER'S COMPENSATION

Separate financial policies are enforced for PI and WC cases. Refer to Adjusting the World Paperwork for details.

MEDICARE

We accept assignment from Medicare and we will submit your claims for you. The check is usually sent directly to our office. The ONLY services that Medicare will cover when provided by a Chiropractor is manual manipulation of the spine. Maintenance and preventative service is not covered. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining 20%. All other services we provide are NONCOVERED. These services include, but are not limited to, x-rays, examinations, therapies, orthotics, supports, and/or nutritional supplements. Medicare patients are fully responsible for charges of non-covered services. Maintenance and preventative service is not covered. Secondary insurance may or may not pay for these non-covered services. Please see IN-NETWORK GROUP OR INDIVIDUAL INSURANCE for payment policy.

FLEX PLANS/MEDICAL SAVINGS ACCOUNTS

If you have a flex spending account we will be happy to provide you with a statement of your charges for reimbursement. (First statement of each year is no charge. Each subsequent statement will have a $5 charge)

INSURANCE FORMS/PAYMENT

If you receive any correspondence from your insurance carrier pertaining to the care you have received at this office or a request of more information regarding your care, please bring it in as soon as possible. It is very important that we keep your file as up to date as possible. Occasionally, either by mistake, or due to provisions in your policy, the check issued by the insurance company for payment of services rendered in our office, may come to you instead of our office. If you should receive any unexpected check in the mail, please contact us to see if it does represent payment of your bill here.

SECONDARY INSURANCE

Please inform us of any secondary insurance.

CASH PAYING PATIENTS

If you do not fall under any of the other categories of payment, you are a **CASH** patient. Since there is no insurance to bill and there are no others responsible for your account, you are expected to pay for your visit at the time of service. You may pay with CASH, CHECK, or CREDIT CARD. We do not carry patient balances unless you have been approved for a payment plan through Care Credit, or have signed up for a monthly payment plan. For Care Credit applications and additional information on how to use Care Credit's no interest payment plans, please ask …We're happy to help!

I have read and understand the payment policy of Adjusting the World Chiropractic. I understand that my insurance is an arrangement between myself and my insurance company, NOT between Adjusting the World Chiropractic and my insurance company. I request that Adjusting the World Chiropractic prepare the customary forms at no charge so that I may obtain insurance benefits. I also understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care as prescribed by the doctors at Adjusting the World Chiropractic that fees will be due and payable immediately.

_____

Patient's signature (or guardian if patient is a minor) Date