

**FRESHOUR CHIROPRACTIC**  
**CONFIDENTIAL CASE HISTORY FOR PREGNANT PATIENT**

*Welcome to our Office and a Healthier Way of Life! Please complete all questions.*

Today's Date \_\_\_\_\_

**Personal Information**

Full Name \_\_\_\_\_ Sex: M/F  
Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_  
Home Phone No. ( ) \_\_\_\_\_ - \_\_\_\_\_ Alternative Phone No. ( ) \_\_\_\_\_ - \_\_\_\_\_  
Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_

**Insurance and Payment Information**

***Primary Insurance***

Insurance Company Name \_\_\_\_\_ Phone No. ( ) \_\_\_\_\_ - \_\_\_\_\_  
Subscriber/Insured's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Subscriber/Insured's Employer \_\_\_\_\_ Subscriber/Insured's Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
Identification # \_\_\_\_\_ Group # \_\_\_\_\_

***Authorization and Assignment***

*I do hereby authorize payments of medical benefits to be made directly to Freshour Chiropractic 379 W Uwchlan Ave Downingtown PA 19335, for services rendered to me. I also authorize Freshour Chiropractic to release any medical information necessary to aid in the processing of my claims.*

Authorized Signature \_\_\_\_\_

***All first visit charges are payable when services are rendered.***

Method of Payment to be used today? Cash    Check    Credit Card

*I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Freshour Chiropractic will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to Freshour Chiropractic will be credited to my account upon receipt. However I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment any fees for professional services rendered to me will be immediately due and payable.*

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

Full Name \_\_\_\_\_

**Pregnancy History**

Age at last menstrual cycle? \_\_\_\_\_ Length of regular menstrual cycle? \_\_\_\_\_

Are your cycles regular? Always \_\_\_\_\_ Never \_\_\_\_\_ Most of the time \_\_\_\_\_

Date of last menstrual cycle? \_\_\_\_\_ Was it normal? \_\_\_\_\_

Date of last x-rays if any? \_\_\_\_\_ Why and by whom? \_\_\_\_\_

Have you had any previous pregnancies? Explain \_\_\_\_\_

Have you had past cesareans? \_\_\_\_\_ How many? \_\_\_\_\_

Have you had a previous D&C? \_\_\_\_\_ How many and dates? \_\_\_\_\_

**Lifestyle**

Allergies \_\_\_\_\_

Do you smoke? \_\_\_\_\_ Did you ever smoke and how long? \_\_\_\_\_

Do you drink? None \_\_\_\_\_ Social(fewer than 2 daily) \_\_\_\_\_ Heavy(2 or more daily) \_\_\_\_\_

List the foods you eat daily and summary of dietary habits \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What type of exercises do you do? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you have any of the following?

Diabetes \_\_\_\_\_ Asthma \_\_\_\_\_ Rh negative blood \_\_\_\_\_ Other chronic problems \_\_\_\_\_

Have you taken birth control pills? \_\_\_\_\_ Type \_\_\_\_\_

Have you used an IUD? \_\_\_\_\_ Date of removal \_\_\_\_\_

Previous Major Illness or Surgery \_\_\_\_\_

Medications you are currently taking or have taken since conception \_\_\_\_\_

\_\_\_\_\_

Name of obstetrician? \_\_\_\_\_ Nurse/Midwife? \_\_\_\_\_

Where do you plan to have your baby? \_\_\_\_\_

**Chiropractic History**

Who referred you to our office? \_\_\_\_\_

Reason for this visit \_\_\_\_\_

Have you ever received chiropractic care? \_\_\_\_\_ Dr's. Name \_\_\_\_\_

Results \_\_\_\_\_

Did you have any health problems during previous pregnancies? Explain \_\_\_\_\_

\_\_\_\_\_

What symptoms of pregnancy have you already experienced? \_\_\_\_\_

\_\_\_\_\_

Additional Comments \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_