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_____
_____
_____