THE DRUGLESS DOCTORS
Chiropractic, Family Health, and Wellness

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Pregnancy Registration Form

Name: _____ Date:_____ File Number: _____
Age: _____ Birth date: _____ Sex: F M E-mail address: _____
Address:_____
Phone:(H)_____ (W)_____ (cell) _____ Marital Status: S M W D
Occupation: _____ Who may we thank for referring you?_____
Family doctor's name and address: _____

Please complete this form as thoroughly as possible. Information on this form is strictly confidential and will not be shared without your consent.

#1 CURRENT HEALTH CONCERNS (explain below)

_____
_____

If there are no current concerns and this assessment is to ensure optimum health, function and wellness mark this box ☐

 # 2 ABOUT YOUR PREGNANCY (circle answer)

Is this your first pregnancy? **Yes / No**
If this is not your first, how many times have you been pregnant? _____
Have you had any complications with previous pregnancies? **Yes / No** (explain if yes)
_____
If you have had miscarriage(s), how far along in your pregnancy did it occur?
_____
Was this pregnancy planned? **Yes / No** What is the estimated date of delivery? _____
Who is your primary care giver 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**
Special arrangements for the birth? Planned C-sec/Water Delivery/Birth Chair/Squat/Other)_____
Would you like additional information on options for birth posturing? **Yes / No**
Have you had any testing? Genetic / Blood / Ultrasound / Amniocentesis / Chorionic Villi 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 you blood pressure prior to pregnancy within: Normal Range / High / Low _____
What is your present blood pressure: _____ When was it last checked? _____
Have you changed your diet/menu since learning of your pregnancy? **Yes / No**
Would you like further information on healthy nutrition for 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** _____

Have you noticed: (If Yes, notate how often)

Swelling in the arms or legs? **Yes / No** _____
Upper back pain? **Yes / No** _____
Rib or chest pain? **Yes / No** _____
Headaches? **Yes / No** _____
Pain radiating down the leg(s)? **Yes / No** _____
Arm or hand numbness/tingling? **Yes / No** _____
Low back pain? **Yes / No** _____
Neck pain? **Yes / No** _____
Any foot pain? **Yes / No** _____
Nausea or vomiting? **Yes / No** _____
Heart palpitations? **Yes / No** _____
Dizziness / lightheadedness? **Yes / No** _____
Digestive complaints? Heartburn, constipation? **Yes/ No** _____

If there is pain from anything noted above is involved, rank it on a scale of 1 to 10 (1 is minimal, 10 is extreme)
_____

Circle or describe the type of pain: sharp / dull / ache / burning / tingling / throbbing / spasms / other

_____

When did you notice it?_____ What happened? _____

What relieves?_____ What aggravates it?_____

Does it radiate or cause problems elsewhere? _____

Any associated or related concerns? _____

Professionals seen for this? (name) _____

Treatment and results_____

Other health concerns: (Please circle all that apply, past or present)

Allergies / Stuffy Nose / Runny Sinuses / Frequent Colds / Lowered Resistance / Loss of Balance / Difficulty Concentrating / Fatigue / Indigestion / Bloating / Appendicitis / Asthma / Bronchitis / Emphysema / Pneumonia Bleeding Disorders / Cancer / Cataracts / Vision Changes / Diabetes / Hypoglycemia / Epilepsy / Heart Disease Hypertension / Migraines / Hepatitis / High Cholesterol / Difficulty w/Digestion / Loose Stools / Hernia / Herniated Disc / Kidney Disease / Liver Disease / Multiple Sclerosis / Osteoarthritis / Rheumatoid arthritis / Osteoporosis Parkinson's Disease / Thyroid Problems / Tonsillitis / Ulcers / Urinary Tract Infections / Ulcerative colitis

Other (list): _____

#3 PHYSICAL STRESSES

Any significant injuries, falls or traumas during infancy or childhood? **Yes / No / Unsure**

(if yes please explain) _____

Any significant injuries, falls or traumas (car accidents) during adulthood? **Yes / No / Unsure**

(if yes please explain) _____

Any hospital visits? **Yes / No** Explain_____

Have you had any surgeries, fractures? **Yes / No** Explain and dates _____

Are you in prolonged postures (ex: repetitive work, lifting, sitting, driving) **Yes / No / Unsure**

(if yes, please explain)_____

Any hobbies that are physically strenuous or have repetitive movements? **Yes / No / Unsure**

(if yes, please explain)_____

What is your usual exercise routine? _____

Any fractured bones or dislocations? _____

Any vehicle accidents? **Yes / No** What happened and when? _____

#4 CHEMICAL STRESSES

Are you taking prescription or over-the-counter medications? **Yes / No**

(If yes, please indicate what you are taking and why) _____

Are you currently taking supplements? **Yes / No**

(if yes, which ones and why?) _____

Do you drink bottled water? **Yes / No / Occasionally**

Are you exposed to pollutants, strong smells, chemicals, aerosols? **Yes / No / Occasionally**

Do you eat organic? **Yes / No / Occasionally** Do you drink or bathe/shower in chlorinated water? **Yes / No**

Do you use natural or environmentally friendly products in your home? **Yes / No**

I.E. Cleaning supplies, hair and makeup, etc. _____

#5 MENTAL/EMOTIONAL STRESSES

Since psychological stress has been shown to affect numerous systems and fetal function, please let us know how you are coping with life's stresses (Rank from 1 - 10 with 1 being minimal stress to 10 being extreme stress).

Life in general I feel _____ Work and Career I feel _____ Relationships I feel _____

Financial stress I feel _____ Time management I feel _____ Sports & hobbies I feel _____

Health and well-being I feel _____ Quality of sleep I feel _____ About my pregnancy I feel _____

If you are experiencing 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 _____

Are you interested in learning about stress reduction practices? **Yes / No**

#6 FAMILY HEALTH HISTORY

Please note any health issues that are present with family members such as parents, siblings, significant other or

children. Cancer / Hypertension / Stroke / Arthritis / Kidney Disease / Dementia / Diabetes
Other: _____

#7 WHY ARE YOU HERE?

People seek chiropractic care for a number of reasons and have certain expectations and perceptions.
Please mark the goals which apply to you so we can accommodate your wishes.

Improvement in function ___	Pain reduction ___	Relief ___	Keep me moving___
Information on prevention ___	Wellness ___	Longevity ___	Stress reduction ___
Symptom management ___	Manage my crisis___	Improved quality of life ___	
Healthier immune system ___	Full body integration___	Improved performance ___	
Optimum function and quality of life ___	Other_____		

#8 INFORMED CONSENT FOR CARE

A practice member, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the practice member in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the practice member susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the practice member to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a practice member by a physician at The Drugless Doctors, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Missed Appointments:

There is a possible cancellation fee charged for appointments that are not canceled in advance. Visits missed while on a care plan must be made up within the time frame of the care plan.

Guarantee of Results:

The purpose of chiropractic care is to improve the health and function of the spine and nervous system. It is not to treat disease, suppress symptoms, medically diagnose, perform surgery or prescribe medications. If you desire any of these we will gladly refer you for those services. Practice member acknowledges that any and all questions regarding benefits, risks and alternatives have been answered to their satisfaction.

Communications:

In the event that we would need to communicate your healthcare information, to whom may we do so?

Spouse: _____Children: _____Others:_____ No one: ___
Please indicate if our office can leave a message on your voicemail regarding your personal health information. Y [ ] N [ ]
Please indicate if we can text office updates in the case of weather alerts or special office announcements. Y [ ] N [ ]
Please indicate if we can send email information to the provided email address through unsecure means. Y [ ] N [ ]

Release of Medical Information:

I certify that I (or my dependent) assign directly to The Drugless Doctors all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize this office to release any information requested by my insurance company to document my claim for benefits. I understand that I am personally responsible for full payment of all charges for my treatment. Services are payable at the time rendered. X-rays remain the property of this clinic and will only be released to another physician after receiving a proper release authorization request from said physician. X-ray will not be released directly to practice members.

Determination of Treatment:

I understand and agree that the doctors of The Drugless Doctors have the right to decline or accept me as a practice member at any time before treatment begins. Taking a history and conducting an examination are a part of the process of information gathering, so that the doctor can determine whether to admit me as a practice member or not.

Minor Consent:

I am authorized to and do consent to all treatments performed by the doctors and staff of The Drugless Doctors and rendered to the minor practice member named on this registration form.

Acknowledgement

I have read and fully understand the above statements. I have received and/or reviewed the notice of privacy practices (HIPAA-Posted at northcoastchiro.net/new-practice member-info) and understand that I have the opportunity to discuss my right to privacy upon request.

Print Name: _____ Signature: _____ Date: _____
Dr. Signature: _____ Robert DeMaria/Anthony DeMaria/Casen DeMaria Date: _____