Welcome

Thank you for choosing our office!

NAME_____ DATE _____ S/S _____-___

BIRTH DATE _____/_____/_____ SEX ASSIGNED AT BIRTH: M / F PRONOUNS: _____

ARE YOU: ☐MARRIED ☐DIVORCED ☐WIDOWED ☐SINGLE ☐DOMESTIC PARTNERSHIP

HOME PHONE # _____CELL PHONE # _____

EMAIL: _____

DO YOU PREFER TO BE CONTACTED VIA: ☐EMAIL ☐PHONE

ADDRESS_____

CITY_____ ZIP_____

YOUR EMPLOYER_____OCCUPATION_____

WORK DUTIES: _____

PERSON TO CONTACT IN CASE OF EMERGENCY _____RELATIONSHIP: _____

PHONE # _____

WHOM MAY WE THANK FOR REFERRING YOU TO US? _____

HAVE YOU BEEN TREATED BY A CHIROPRACTOR BEFORE☐YES☐NO

IF YES WHEN WAS YOUR LAST ADJUSTMENT_____

HAVE YOU BEEN TREATED BY ANYONE ELSE FOR THIS CONDITION?☐YES☐NO

IF SO PLEASE DESCRIBE:_____

DO YOU NEED A REFERRAL OR RECOMMENDATION TO A PROVIDER? (DOULA, MIDWIFE, PEDIATRICIAN, PELVIC FLOOR PT)

☐YES ☐NO IF YES , WHICH REFERRAL/RECOMMENDATION ARE YOU LOOKING FOR?

_____

PREVIOUS BIRTH EXPERIENCE

IS THIS YOUR FIRST PREGNANCY?☐YES ☐NO

IF NOT, PLEASE TELL US ABOUT YOUR PREVIOUS PREGNANCY AND/OR BOTH EXPERIENCE(S). DURATION, INTERVENTIONS, ETC)

_____

_____

CONCEPTION AND EARLY PREGNANCY

DUE DATE/ WEEKS PREGNANT _____

I AM HAVING ☐BOY ☐GIRL ☐SURPRISE ☐NOT SURE YET ☐TWINS :_____

BIRTH TEAM (OB/MW/DOULA) AND

LOCATION:_____

_____

WHERE DO YOU PLAN TO DELIVER?_____

100 O'Connor Drive Suite 25, San Jose, CA 95128 www.afamilychiro.com
T: 408.271.2800 Fax: 408.271.2827

Did you have difficulty conceiving? ☐Yes ☐No. If yes, please explain:

_____

current Health conditions

While pregnant have you had or are you experiencing any of these conditions below:

☐Low Back Pain ☐SI Pain ☐Pubic Symphysis Pain ☐Hip Pain ☐Middle Back Pain ☐Rib Pain

☐Round Ligament Pain ☐Carpal tunnel ☐Heel/foot Pain ☐Pelvic Floor Dysfunction ☐Diastasis recti

Reason for your visit:_____

_____

When did you first start to notice the symptoms:_____

Is this condition getting progressively worse: _____

Is the pain constant or does it comes and go: _____

Have you experienced any of the following?

☐Nausea ☐Vomiting ☐Heart Burn ☐Bloating ☐Slower Digestion ☐Food Aversions

☐Food Cravings ☐Hemorrhoids ☐Varicose Veins ☐Constipation. ☐Urinary Incontinence

☐Increase in Urinary frequency ☐Increased Gas ☐Fatigue/exhaustion ☐Insomnia ☐Leg Cramps

☐ Sensitive Breasts ☐Swelling. ☐Headaches ☐Dizziness ☐Lightheadedness ☐Shortness of Breath ☐High Blood Pressure ☐Irritability ☐Forgetful ☐Mood Swings

☐Anxiety or Depression ☐Braxton-Hicks

What type of exercise(s) are you currently performing?

_____

_____

Please tell us about your current diet, and any dietary restrictions

_____

_____

Have you taken medications or supplements during your pregnancy? ☐Yes ☐No

☐Prenatal ☐DHA ☐Probiotics ☐Magnesium ☐Vit D ☐Iron

If yes: Please list medication, brand of supplementation

_____

Have you had any :

☐ Falls during Pregnancy ☐Big Stressors during Pregnancy ☐Hospitalizations during Pregnancy

☐Physical Traumas during Pregnancy ☐Significant injury to your tailbone in your lifetime

☐Placenta Previa ☐Preclampsia ☐ Cerclage ☐ Extreme Abdominal Pain

☐Low Back Pain with Bowel or Bladder Dysfunction

☐Placenta Abruption ☐Vaginal Discharge ☐Period like cramps

If yes, please explain if you are currently getting treated or have been treated for any of these conditions:

_____

_____

Your Birth Plan

Goals for Pregnancy, Labor/Birth, and Postpartum:

_____

_____

Do you currently have a Birth Plan? ☐Yes ☐No

if yes, please explain._____

_____

Are you taking any Prenatal or Birthing classes☐Yes ☐No , If yes, what are you taking?._____

Do you wish to have a natural vaginal labor or delivery? ☐Yes ☐No

if not, what concerns do you have?_____

After 32nd Week of Pregnancy

Position of Baby if known: ☐Head Down ☐Breech ☐Posterior ☐Unknown

Confirmed By: ☐Palpation ☐Ultrasound & when :_____

If you've been tested for GBS+ during your current pregnancy, were you positive or negative?

☐GBS +☐GBS-

Have you been GBS + in past pregnancies ☐Yes ☐No

Did you receive antibiotics ☐Yes ☐No

Your Post-Birth Plan?

What fears or hesitations do you have about pregnancy, birth or postpartum

_____

_____

Do you plan to breastfeed? ☐Yes ☐No

What is your plan for support postpartum? How long do you intend to rest postpartum?

_____

_____

What activities and exercise/fitness would you like to return to postpartum?

_____

_____

Anything you would like to add that was addressed above?

_____

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Weekly Belly Pictures

Expecting mothers can take week-by-week photos on our beautiful floral background to capture their growing baby and the amazing changes their body goes through.

☐ yes would love to! ☐Still thinking about it ☐ No Thanks!

Social Media Consent

Thank you for participating in our social media page. We would greatly appreciate you filling out this form to get an understanding of how and where we are permitted to use your photographs. We plan to use these photographs as an educational and marketing tool.

I _____ Hereby give permission for posting our photographs.

Please Select All that Apply:
☐ Facebook ☐ Office ☐ Instagram ☐ Website ☐ Newsletter ☐ Yelp/Google

I _____ Hereby give permission for releasing the following marked information:

Please Select All that Apply:
☐ First Name ☐ Name of my condition ☐ Image ☐ Video ☐ Testimonial Quote

I _____DO NOT GIVE PERMISSION TO POST OR USE ANY PHOTOGRAPHS/VIDEOS

Additional Comments:

_____

_____

I consent to use my videos, photographs, on the above checked off sections indicated by me and I understand that I can always revoke the consent by contacting our office in writing.

Signed: _____ Date: ____/_____/_____

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Consent

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE HIPAA NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

PRACTICE'S REQUIREMENTS

*. The Practice:

- Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.
- Is required to abide by the terms of this Privacy Notice.
- Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains.
- Will distribute any revised Privacy Notice to you prior to implementation.
- Will not retaliate against you for filing a complaint.

_____ _____ _____

Patient Name Patient/Guardian Signature Date

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE CHIROPRACTIC INFORMED CONSENT TO TREAT

I have read the attached explanation of the chiropractic adjustment and related treatment. I have discussed it with my treating doctor and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

_____ _____ _____

Patient Name Patient/Guardian Signature Date

_____ _____ _____

Witness Name Witness Signature Date

AUTHORIZATION

Our office policy maintains that payment is due at the time service is rendered. This includes your co-pay or deductible.

Please be prompt in keeping appointments. If you need to re-schedule an appointment, kindly give us **-hour notice, otherwise you are subject to a fee for the time we have reserved for you.

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I authorize and request my insurance company to pay directly to the chiropractor. I understand that my chiropractic insurance company may pay less than the actual bill of service. I agree to be responsible for payment of all services rendered on my behalf or dependents.

_____ _____ _____

Patient Name Patient/Guardian Signature Date