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www.resiliencechiropractic.com

RESILIENCE CHIROPRACTIC

PREGNANCY INTAKE PAPERWORK

HELLO AND WELCOME TO RESILIENCE!

Who may we thank for referring you / how did you hear about us? _____

Have you received chiropractic care in the past? ❑ No ❑ Yes (from whom?) _____

Please fill out the following information completely and to the best of your ability.
Remember to initial the bottom of each page.

PERSONAL INFORMATION

Name: _____ Date of Birth: _____ Age: _____

Preferred Name: _____ Gender: ❑ Male ❑ Female

Email: _____ Marital Status: ❑ S ❑ M ❑ D ❑ W

Street Address: _____ City/State/Zip: _____

Cell Phone: _____ Home Phone: _____

Occupation/Employer: _____ Work Phone: _____

Emergency Contact: _____ Relationship to You: _____

Cell Phone: _____ Hobbies: _____

Name(s) & Age(s) of Children: _____

PERSONAL HEALTH HISTORY & PREGNANCY

List your current:

Height: ___ ft. ___ in.

Weight: _____lbs.

What is your typical daily work activity?

❑ Sitting ❑ Standing ❑ Light Lifting ❑ Heavy Lifting ❑ Driving

❑ Working at a Computer ❑ Manual Labor ❑ Other: _____

Do you have any genetic disorders or disabilities? ❑ No ❑ Yes (If yes, *explain*): _____

_____

Indicate if you have experienced any of the following: ❑ N/A

❑ Serious illnesses, operation, or health emergency

❑ Been unconscious due to an illness or injury

❑ Been in a motor vehicle accident

❑ Fractured a bone

Explain (include year(s)): _____

List any over-the-counter/prescription drugs and vitamins/supplements that you are currently taking: ❑ N/A _____

_____

Current Tri ❑ 1 ❑ 2 ❑ 3 **/ Week:** ___ **Name of** ❑ Doctor / ❑ Midwife: _____

Expected Due Date: _____ **First Day of Last Menstrual Period:** _____

SOCIAL HISTORY

Do you smoke?	❑ Never	❑ In the Past	❑ Occasionally	❑ Daily
Are you exposed to secondhand smoke?	❑ Never	❑ In the Past	❑ Occasionally	❑ Daily
Do you drink alcohol?	❑ Never	❑ In the Past	❑ __Drinks/Week	❑ Daily
Do you use recreational drugs?	❑ Never	❑ In the Past	❑ Occasionally	❑ Daily
How often do you exercise?	❑ Never	❑ In the Past	❑ Occasionally	❑ Daily

INITIALS _____

CHIEF COMPLAINT / HISTORY OF PRESENTING ILLNESS

What is the MAIN symptom/pain/reason you are seeking chiropractic care?

PROBLEM/CONCERN #1: _____

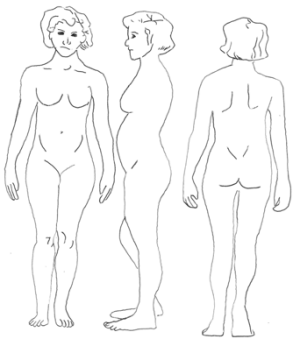
- WHEN did this problem begin? _____ Is it constant or intermittent? _____
- Did you do something / did something happen that aggravated the problem? ❑ No ❑ Yes
  Explain: _____
- WHEN is the problem at its worst? ❑ Morning ❑ Mid-day ❑ Evening ❑ Other _____
- Does the problem RADIATE outward from a source? _____
- What RELIEVES the problem? _____
- What makes the problem WORSE? _____

Are there any SECONDARY health concerns you wish to bring to our attention? ❑ No ❑ Yes

PROBLEM/CONCERN #2: ❑ N/A _____

- WHEN did this problem begin? _____ Is it constant or intermittent? _____
- Did you do something / did something happen that aggravated the problem? ❑ No ❑ Yes
  Explain: _____
- WHEN is the problem at its worst? ❑ Morning ❑ Mid-day ❑ Evening ❑ Other _____
- Does the problem RADIATE outward from a source? _____
- What RELIEVES the problem? _____
- What makes the problem WORSE? _____

DIRECTIONS: CIRCLE the area(s) on the diagram that relate to your pain/symptom(s)/issue(s):



How would you describe the problem(s)?

❑ Dull ache ❑ Burning ❑ Stiff/Tight ❑ Deep, boring
❑ Tingling ❑ Radiating ❑ Pounding ❑ Sharp/Stabbing
❑ Numb ❑ Other: _____

PAST HISTORY

Has your symptom/pain/reason for seeking chiropractic care happened BEFORE? ❑ No ❑ Yes

- If yes, how many times? ❑ N/A _____
- What sort of treatment did you seek before? ❑ N/A _____
- What were the results of your previous treatment? ❑ N/A _____

Help us identify past conditions or procedures that could be related to your main issue:

❑ Past surgeries ❑ Childhood diseases ❑ Past injuries ❑ N/A *Explain*: _____

_____

Have you experienced or been diagnosed with any of the following? ❑ N/A

❑ Pain that wakes you up at night ❑ Night Sweats ❑ Stroke ❑ Heart Attack ❑ Diabetes
Explain: _____

INITIALS _____

QUADRUPLE VISUAL ANALOG SCALE

Name: _____ Date: _____

PLEASE READ CAREFULLY

DIRECTIONS: Fill in your problem(s)/concern(s) from the previous page. *Regarding these problem(s)/concern(s),* please CIRCLE the number that best describes the question being asked.

PROBLEM/CONCERN #1: _____

1. What is your pain RIGHT NOW?

No Pain _____ Worst Pain Possible

0 1 2 3 4 5 6 7 8 9 10

2. What is your TYPICAL or AVERAGE pain?

No Pain _____ Worst Pain Possible

0 1 2 3 4 5 6 7 8 9 10

3. What is your pain AT ITS BEST (How close to "0" does your pain get at its best)?

No Pain _____ Worst Pain Possible

0 1 2 3 4 5 6 7 8 9 10

4. What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No Pain _____ Worst Pain Possible

0 1 2 3 4 5 6 7 8 9 10

PROBLEM/CONCERN #2: ❑ N/A _____

1. What is your pain RIGHT NOW?

No Pain _____ Worst Pain Possible

0 1 2 3 4 5 6 7 8 9 10

2. What is your TYPICAL or AVERAGE pain?

No Pain _____ Worst Pain Possible

0 1 2 3 4 5 6 7 8 9 10

3. What is your pain AT ITS BEST (How close to "0" does your pain get at its best)?

No Pain _____ Worst Pain Possible

0 1 2 3 4 5 6 7 8 9 10

4. What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No Pain _____ Worst Pain Possible

0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS: _____

(OFFICE USE ONLY) 1 ____ 2 _____

INITIALS _____

ACTIVITIES OF DAILY LIVING

DIRECTIONS: Assess your ability / lack of ability to complete the following activities.

Activity	CAN COMPLETE			CANNOT COMPLETE Due to Pain	N/A
	Without Pain or Difficulty	*With Minimal* Pain or Difficulty	*With Significant* Pain or Difficulty		
Bathe/Shower	❑	❑	❑	❑	❑
Groom Hair	❑	❑	❑	❑	❑
Brush Teeth	❑	❑	❑	❑	❑
Use Toilet	❑	❑	❑	❑	❑
Dress Upper Body	❑	❑	❑	❑	❑
Dress Lower Body	❑	❑	❑	❑	❑
Daily Physical Activities	❑	❑	❑	❑	❑
Stand	❑	❑	❑	❑	❑
Walk	❑	❑	❑	❑	❑
Sit	❑	❑	❑	❑	❑
Squat	❑	❑	❑	❑	❑
Kneel	❑	❑	❑	❑	❑
Reach Overhead	❑	❑	❑	❑	❑
Bend Forward	❑	❑	❑	❑	❑
Turn Left	❑	❑	❑	❑	❑
Turn Right	❑	❑	❑	❑	❑
Move from Seated to Standing	❑	❑	❑	❑	❑
Sleep	❑	❑	❑	❑	❑
Eat	❑	❑	❑	❑	❑
Go Up/Down Stairs	❑	❑	❑	❑	❑
Get In/Out of Car	❑	❑	❑	❑	❑
Drive	❑	❑	❑	❑	❑
Use Computer	❑	❑	❑	❑	❑
Focus/Concentrate	❑	❑	❑	❑	❑
Prepare Food	❑	❑	❑	❑	❑
Household Chores	❑	❑	❑	❑	❑
Lift Children	❑	❑	❑	❑	❑
Carry Bag/Purse	❑	❑	❑	❑	❑
Run/Hike	❑	❑	❑	❑	❑
Sexual Activity	❑	❑	❑	❑	❑
Other: _____	❑	❑	❑	❑	❑

INITIALS _____

REVIEW OF SYSTEMS & ORGAN DYSFUNCTION

DIRECTIONS: Check the box(es) that apply to conditions that you or your family members currently suffer from or have suffered from in the past.

CONDITION	SELF	CHILD	SIBLING	PARENT	GRANDPARENT
Acid Reflux/Heartburn/GERD	❑	❑	❑	❑	❑
ADHD/ADD	❑	❑	❑	❑	❑
Allergies	❑	❑	❑	❑	❑
Anxiety	❑	❑	❑	❑	❑
Arthritis/Joint Pain	❑	❑	❑	❑	❑
Asthma/Difficulty Breathing	❑	❑	❑	❑	❑
Autism Spectrum	❑	❑	❑	❑	❑
Cancer	❑	❑	❑	❑	❑
Carpal Tunnel Syndrome	❑	❑	❑	❑	❑
Chest Pain	❑	❑	❑	❑	❑
Depression	❑	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑	❑
Difficulty Sleeping	❑	❑	❑	❑	❑
Disc Problems	❑	❑	❑	❑	❑
Dizziness/Vertigo	❑	❑	❑	❑	❑
Ear Problems	❑	❑	❑	❑	❑
Epilepsy	❑	❑	❑	❑	❑
Fibromyalgia	❑	❑	❑	❑	❑
Headaches/Migraines	❑	❑	❑	❑	❑
Hemorrhoids	❑	❑	❑	❑	❑
High/Low Blood Pressure	❑	❑	❑	❑	❑
Infertility	❑	❑	❑	❑	❑
Irritable Bowel Syndrome	❑	❑	❑	❑	❑
Menstrual Dysfunction	❑	❑	❑	❑	❑
Mood Changes/Irritability	❑	❑	❑	❑	❑
Numbness/Tingling	❑	❑	❑	❑	❑
Scoliosis	❑	❑	❑	❑	❑
Sinus Problems	❑	❑	❑	❑	❑
Swelling of Legs/Feet	❑	❑	❑	❑	❑
TMJ/Jaw Pain	❑	❑	❑	❑	❑
Tremors	❑	❑	❑	❑	❑
* Organic / System Problems	❑	❑	❑	❑	❑

* **Select ALL that apply:** ❑ Digestive ❑ Gallbladder ❑ Heart ❑ Liver ❑ Stomach ❑ Pancreas ❑ Reproductive ❑ Lung/Respiratory ❑ Urinary ❑ Kidney ❑ Prostate ❑ Vision ❑ Thyroid ❑ Skin ❑ Sexual ❑ Other(s) _____ ***Explain***: _____

_____

INITIALS _____

Name: _____ Date: _____

TERMS OF ACCEPTANCE

Please read the below and if you have any questions, feel free to ask one of our staff members.

RESILIENCE CHIROPRACTIC NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled '**HIPAA'** on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes - discussion with other health care providers involved in your care.
2. Inadvertent disclosures - open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes - to process a claim or aid in investigation.
5. Emergency - in the event of a medical emergency we may notify a family member.
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement - to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons - discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders - we may call your home and leave messages regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain one copy of your records at no charge, when timely notice is provided (72 hours). X-rays are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS: If you wish to make a formal complaint about how we handle your health information, please call Dr. Rob Michaud (269) 389-0345. If he is unavailable, you may make an appointment with our receptionist to see her within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to DHHS, Office of Civil Rights, 200 Independence Ave. SW, Room 509F HHH Building, Washington DC 20201.

Signature: _____ **Date:** _____

INITIALS _____

RESILIENCE CHIROPRACTIC NOTICE REGARDING YOUR RIGHT TO PRIVACY (CONTINUED)

I have received a copy of Resilience Chiropractic Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present. I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

Name: _____ **Date:** _____

Signature: _____ **Date of Birth:** _____

INFORMED CONSENT

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient 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 patient 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 patient 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 patient by a physician at Resilience Chiropractic, 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.

Signature: _____ **Date:** _____

AUTHORIZATION FOR X-RAYS

X-rays are utilized in the office to help location and analyze **vertebral subluxations**. These x-rays are not to be used to investigate for medical pathology. The doctors of Resilience Chiropractic do not diagnose or treat medical conditions; however if any abnormalities are found, they will be brought to your attention so that you can seek proper medical advice. By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays.

By signing below, I confirm that I **AM/**believe **I MAY BE** pregnant, therefore I **DO NOT** authorize Resilience Chiropractic to X-ray me at this time.

Signature: _____ **Date:** _____

After careful consideration, I do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case **AFTER** my pregnancy.

Signature: _____ **Date:** _____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I authorize Resilience Chiropractic to release all necessary information concerning my health condition to my billing company, insurance company, attorney, and/or adjuster in order to process any claim for reimbursement of charges incurred by me. In addition, I authorize Resilience Chiropractic to release any information regarding my health condition to other health care providers involved in my care. This assignment will remain in effect until revoked by me in writing. I agree that a photocopy of this form is to be considered as valid as the original. I confirm that all information I have provided is true and correct to the best of my knowledge. I confirm that I have read and fully understand this agreement and authorize Resilience Chiropractic to proceed with chiropractic tests, diagnosis, analysis, and adjustments.

Signature: _____ **Date:** _____

INITIALS _____