T C/D1 A X

PDR
Date: _____
Time: _____

FREEDOM CHIROPRACTIC

Pregnant New Practice Member Application

Name _____ Date of Birth _____ /_____ /_____ Age _____ Male / Female

Address _____ City _____ State _____ Zip _____

Phone (Cell) _____ (Home) _____

Email Address _____ Occupation _____

Employer's Name _____ Single / Married / Divorced / Widowed

Insurance Provider (circle): BCBS UHC Aetna Cigna Medicare Other_____

Spouse's Name _____ Number of Children _____

Names, Ages, & Gender _____

Who may we thank for referring you? _____

HISTORY OF PREGNANCY(s)

Conception + Early Pregnancy

Due date: _____ / _____ / _____ How far along: _____ Gender(s): _____

Did you have difficulty conceiving? Yes No

If yes, please explain: _____

Where do you plan to deliver? Home Birth Center Hospital Other: _____

Previous Birth Experience

Is this your first pregnancy? Yes No If no, how many pregnancies have you had? _____

Please circle ALL that apply to your previous pregnancy and / or birth experience(s):

Preterm labor	Constipation	Tearing – What Degree? _____
Malpositioning	Sciatica	Episiotomy
Hyperemesis Gravidarum	Preeclampsia	Prolapse
Symphysis Pubis Dysfunction (SPD)	Eclampsia	Diastasis Recti

Where did your previous births take place (home, birth center, hospital, etc.)? _____

For Each Pregnancy

How long was your labor? _____

How long did you push? _____

Did you receive an epidural? Yes No

If Yes, did you ever experience symptoms related to the epidural (i.e. back pain, numbness, paralysis, etc.)?

_____

Was your labor spontaneous or was induction required? _____

Were any interventions used? Yes No

If Yes, which? C-Section Vacuum Delivery Forceps Delivery

Current Health Conditions

What types of exercises are you currently performing (yoga, spinning babies, hypnobabies, etc.)?

_____

Have you had any slips, falls, hospitalizations or other physical traumas during this pregnancy? Yes No
If yes, please explain: _____

Have you ever had a significant injury to your sacrum, coccyx, pelvis, hip, or any other significant injury or medical history that could affect your pregnancy or childbirth? Yes No
If yes, please explain: _____

Have you had any major emotional stressors during the pregnancy? Yes No
If yes, please explain: _____

After 32nd Week of Pregnancy ONLY

Position of baby (circle one):

Head down Transverse
Breech Unknown

Confirmed by and when?

Palpation – Date ____ / ____ / _____
Ultrasound – Date ____ / ____ / _____

LIST THE HEALTH CONCERNS THAT BROUGHT YOU INTO THIS OFFICE

Health Concerns (list according to severity)	Rate of Severity (0=no pain, 10=unbearable)	When did this problem begin?	Have you had the problem before? When?	Are symptoms constant (C) or intermittent (I)?
Primary				
Second				
Third				
Fourth				

Have you seen other doctors for these conditions? Yes No
If yes: ____ Chiropractor ____ Medical Doctor Other: _____
Who? _____ When? _____ Results? _____

PLEASE MARK "P" FOR IN THE PAST OR MARK "C" FOR CURRENTLY HAVE

___ Headaches
___ Migraines
___ Jaw/TMJ Pain
___ Neck Pain
___ Shoulder Pain
___ Arm Pain
___ Upper Back Pain
___ Mid Back Pain
___ Lower Back Pain
___ Hip/Leg Pain
___ Knee Pain
___ Foot Pain
___ Ear Infections
___ Hearing Loss
___ Ringing in the Ears
___ Dizziness
___ Loss of Energy
___ Nervousness
___ Double/Blurry Vision
___ Anxiety
___ ADD/ADHD
___ Loss of Balance
___ Depression
___ Allergies
___ Sinus Issues
___ Frequent Colds
___ Thyroid Issues
___ Asthma
___ Chest Pain
___ Heart Problems
___ Nausea
___ Ulcers
___ Digestive Issues
___ Diarrhea
___ Constipation
___ Bed Wetting
___ Kidney Problems
___ Bladder Problems
___ Menstrual Problems
___ Prostate Problems
___ Infertility
___ Fibromyalgia
___ Epilepsy/Convulsions
___ Tremors
___ Disc Problems
___ Muscle Spasms
___ Poor Posture
___ Skin Problems
___ Sexual Dysfunction
___ Sleep Problems
___ Tight/Sore Muscles
___ Sports Injury
___ Sciatica
___ Arthritis/Joint Pain
___ GERD/Gastric Reflux
___ Numb/Tingling in Arms/Hands
___ Numb/Tingling in Legs/Feet
___ Stomach Problems
___ High/Low Blood Pressure
___ Difficulty Breathing

___Stroke ___Cancer ___Heart Attack ___Spinal Surgery ___Spinal Bone Fracture ___Scoliosis ___Diabetes ___Arthritis ___Seizures

Other:_____

List ALL surgical operations and years: _____

_____

List any other injuries to your spine, minor or major, that the Doctor should know about: _____

_____

List ALL over the counter and prescription medications you are on and the reason for each: _____

_____

Have you ever been in an auto accident? List all: _____

_____

Have you ever been knocked unconscious? Yes No Fractured a bone? Yes No

If yes to either of the above, please describe: _____

Other trauma: _____

Chemical & Environmental Exposure (please rate your CONSUMPTION for each: 1 = None, 5 = High)

Smoking	1	2	3	4	5	Dairy	1	2	3	4	5
Alcohol	1	2	3	4	5	Gluten	1	2	3	4	5
Sugar	1	2	3	4	5	Processed Foods	1	2	3	4	5
Caffeine	1	2	3	4	5	Recreational Drugs	1	2	3	4	5

Stresses & Challenges (please rate your STRESS for each: 1 = None, 5 = High)

Home	1	2	3	4	5
Work	1	2	3	4	5
Money	1	2	3	4	5
Health	1	2	3	4	5
Family	1	2	3	4	5
Life	1	2	3	4	5

QUADRUPLE VISUAL ANALOGUE SCALE

Please circle the number that best describes the question asked, 0=no pain and 10=unbearable. If you have more than one complaint, please answer each question for each individual complaint and indicate the score of each complaint.

1. How would you rate your pain RIGHT NOW?

   0 1 2 3 4 5 6 7 8 9 10

2. What is your typical or AVERAGE pain?

   0 1 2 3 4 5 6 7 8 9 10

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

   What percentage of your awake hours is your pain at its BEST? _____%

   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?)

   What percentage of your awake hours is your pain at its WORST? _____%

   0 1 2 3 4 5 6 7 8 9 10

Practice Member name (that's you!): _____ Date: _____

ACTIVITIES OF LIFE

Please circle how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITY:	EFFECT:			
Carrying Groceries	No Effect	Painful (can do)	Painful (limits)	Unable to perform
Sit to Stand	No Effect	Painful (can do)	Painful (limits)	Unable to perform
Climbing Stairs	No Effect	Painful (can do)	Painful (limits)	Unable to perform
Pet Care	No Effect	Painful (can do)	Painful (limits)	Unable to perform
Driving	No Effect	Painful (can do)	Painful (limits)	Unable to perform
Extended Computer Use	No Effect	Painful (can do)	Painful (limits)	Unable to perform
Household Chores	No Effect	Painful (can do)	Painful (limits)	Unable to perform
Lifting Children	No Effect	Painful (can do)	Painful (limits)	Unable to perform
Dressing	No Effect	Painful (can do)	Painful (limits)	Unable to perform
Shaving	No Effect	Painful (can do)	Painful (limits)	Unable to perform
Sexual Activities	No Effect	Painful (can do)	Painful (limits)	Unable to perform
Sleep	No Effect	Painful (can do)	Painful (limits)	Unable to perform
Static Sitting	No Effect	Painful (can do)	Painful (limits)	Unable to perform
Static Standing	No Effect	Painful (can do)	Painful (limits)	Unable to perform
Walking	No Effect	Painful (can do)	Painful (limits)	Unable to perform
Washing/Bathing	No Effect	Painful (can do)	Painful (limits)	Unable to perform
Sweeping/Vacuuming	No Effect	Painful (can do)	Painful (limits)	Unable to perform
Dishes	No Effect	Painful (can do)	Painful (limits)	Unable to perform
Laundry	No Effect	Painful (can do)	Painful (limits)	Unable to perform
Yard work	No Effect	Painful (can do)	Painful (limits)	Unable to perform
Garbage	No Effect	Painful (can do)	Painful (limits)	Unable to perform
Concentration (Reading)	No Effect	Painful (can do)	Painful (limits)	Unable to perform
Other: _____	No Effect	Painful (can do)	Painful (limits)	Unable to perform
Other: _____	No Effect	Painful (can do)	Painful (limits)	Unable to perform

List your Top 3 Health Goals:

1. _____
2. _____
3. _____

List your Top 3 Pregnancy + Delivery Goals:

1. _____
2. _____
3. _____

FAMILY HEALTH HISTORY

This form is to assist the Doctor by providing past health history information for their review.

CONDITION	SPOUSE	SON	DAUGHTER	MOTHER	FATHER
Headaches					
Neck Pain					
Jaw/TMJ Pain					
Shoulder Pain					
Back Pain					
Hip/Leg Pain					
Arthritis/Joint Pain					
Ear Infections					
Hearing Loss					
Dizziness					
Loss of Energy					
Nervousness					
Blurred/Double Vision					
Anxiety					
ADD/ADHD					
Depression					
Allergies					
Sinus Issues					
Thyroid Problems					
Asthma					
Breathing Problems					
Heart Problems					
High/Low Blood Pressure					
Stomach Problems					
Bed Wetting					
Infertility					
Sciatica					
Fibromyalgia					
Poor Posture					
Sleep Problems					
Stroke					
Cancer					
Heart Disease					
Diabetes					
Arthritis					
Alzheimer's					

Informed Consent for Chiropractic Care

Chiropractic care, like all forms of health care, while offering considerable benefits may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases, injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include: sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care occuring at a rate between one instance per one million to one per to million cervical spine (neck) adjustments may be a vertebral injury that could lead to a stroke.

Prior to receiving chiropractic care in the chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific conditions, your overall health and in particular your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

I understand and accept that there are risks associated with chiropractic care and give consent to the examination that the doctor deems necessary and the chiropractic care, including spinal adjustments, as reported following my assessment.

I authorize and request payment of insurance benefits directly to Dr. Colton Bideler, D.C. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the practice member. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

Print name: _____

Signature:_____ Date: _____

If This Health Profile is for a Minor/Child, Please Fill Out and Sign Below
Written Consent for a Child

Name of Practice Member who is a minor/child: _____

I authorize Dr. Colton Bideler, D.C. and any and all Freedom Chiropractic staff to perform diagnostic procedures, radiographic evaluations, render chiropractic care, and perform chiropractic adjustments to my minor/child. As of this date, I have the legal right to select and authorize health care services for my minor/child. If my authority to select and authorize care is revoked or altered, I will immediately notify Freedom Chiropractic.

Guardian signature: _____ Date: _____

Relationship to minor/child: _____

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

1. Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physicians' certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

Signature: _____ Date: _____

We love to have pictures in our office!
If you would allow us to have your picture in the office, please sign below

For valuable consideration, I hereby irrevocably consent to and authorize the use and reproduction by Freedom Chiropractic, or anyone authorized by Freedom Chiropractic, of any and all photographs/videos which were taken of myself and/or my child, for the purposes of promotional TV, website, social media, and/or print ad whatsoever, without further compensation to me. All negatives and positives, together with the prints, shall constitute the property of Freedom Chiropractic, solely and completely. Any information voluntarily provided by a patient shall also be used in conjunction with the above listed information for purposes previously mentioned. Confidentiality, in regard to any reported conditions, is also waived to the extent of information pertinent to the promotion material only. I authorize Freedom Chiropractic to share this information via their website and their social media platforms including but not limited to Facebook and Instagram, and for use in the office. All other unrelated patient information shall remain private and protected (according to Health Information and Privacy Act laws).

Signature: _____ Date: _____

File # _____

X-Ray Authorization

(No earlier than 6 weeks postpartum)

As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files. At your request, we will provide you with a copy of your x-rays in our files. The fee for copying your x-rays on a disc is $10. Digital x-rays on a CD will be available within 72 hours of request on any regular practice hours day. Please note: x-rays are utilized in this office to help locate and analyze vertebral subluxations. The Doctor of Freedom Chiropractic does not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice.

By signing below, you are agreeing to the above terms and conditions.

Print name: _____ Date of Birth: _____

Signature: _____ Date: _____

FEMALES ONLY: To the best of my knowledge, I BELIEVE I AM NOT PREGNANT at the time the x-rays are taken at Freedom Chiropractic.

Signature: _____ Date: _____

---------- DO NOT WRITE BELOW THIS LINE ----------

Cervicals (cm)	**Thoracics (cm)**	**Lumbars (cm)**
Lateral Cervical	Lateral Thoracics	Lateral Lumbar
AP Cervical	AP Thoracic	AP Lumbar
APOM		
Flexion/Extension		
Obliques		