PATIENT'S NAME: _____ PM#_____ Date: ____/_____/_____

Expedition Chiropractic Pregnancy Intake Paperwork

Today's Date: _____ PM#: _____

PATIENT DEMOGRAPHICS

Name: _____ Birthdate: _____-_____-_____ Age: _____ □ Male □ Female

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

E-mail Address: _____ Marital Status: □ Single □ Married

Employer: _____ Occupation: _____

Spouse's Name _____ Spouse's Employer _____

Number of children and ages: _____

Name & Number of Emergency Contact: _____Relationship: _____

HISTORY OF COMPLAINT

Please identify the condition(s) that brought you to this office: Primary: _____

Secondary: _____ Third: _____ Fourth: _____

On a scale of 0 to 10 with 10 being the worst pain and zero being no pain, rate your above complaints by circling the number:

Primary or chief complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Second complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Third complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Fourth complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When did the problem(s) begin? _____ When is the problem at its worst? □ AM □ PM □ mid-day □ late PM

How long does it last? □ It is constant OR □ I experience it on and off during the day OR □ It comes and goes throughout the week

How did the injury happen? _____

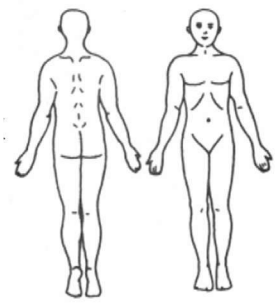
Condition(s) ever been treated by anyone in the past? □ No □ Yes If yes, when? _____ by whom? _____

How long were you under care? _____ What were the results?_____

Name of previous chiropractor: _____ □ N/A

PLEASE MARK the areas on the body diagram with the following letters to describe your symptoms:

R = Radiating B = Burning D = Dull A = Aching N = Numbness S = Sharp/Stabbing T = Tingling



What relieves your symptoms? _____

What makes your symptoms feel worse? _____

PATIENT'S NAME: _____ PM#_____ Date: ____/_____/_____

LIST RESTRICTED ACTIVITY	CURRENT ACTIVITY LEVEL	USUAL ACTIVITY LEVEL

Is your problem the result of ANY type of accident? □ Yes □ No
Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

_____

_____

PREGNANCY

Did you experience any fertility issue(s) or miscarriage(s) prior to your pregnancy? ___ No ___Yes, Explain:

_____

What is your expected due date? _____
What trimester & week of pregnancy are you currently? Trimester: _____ Week: _____
List the name of your Doctor/Midwife: _____
Is this your first pregnancy? Yes ____ No ____
Would you like to have your baby start chiropractic care here at our office? Yes ___ No ___ Undecided ___, Explain: _____
How do you plan to feed your newborn baby? Pump/Bottle-feed: Breastmilk _____ Bottle Feed: Formula _____
Do you plan to vaccinate your child? Yes _____ No _____
Have you had any trouble sleeping during your pregnancy? Yes _____ No_____
Are you taking any over-the-counter/prescription drug, vitamin/supplement or natural remedy? No ____ Yes____
List name & reason for taking: _____
What is your typical daily work activity? (Check all that apply) Working at a computer_____ Excessive sitting_____ Excessive standing ____ Excessive driving____ Lifting____ Low Stress____ Moderate Stress ____ High Stress _____
Other: _____

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? □ No □ Yes If yes, how many times? _____ When was the last episode? _____ How did the injury happen? _____

Other forms of treatment tried: □ No □ Yes If yes, please state what type of treatment: _____, and who provided it? _____ How long ago? _____ What were the results? □ Favorable □ Unfavorable Please explain: _____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

_____

If you have ever been diagnosed with any of the following conditions, please indicate with:

P for in the Past C for Currently have N for Never have had

___ Broken Bone ___ Dislocations ___ Tumors ___ Rheumatoid Arthritis ___ Fracture ___ Disability ___ Cancer

___ Heart Attack ___ Osteo Arthritis ___ Diabetes ___ Cerebral Vascular ___ Other serious conditions: _____

PATIENT'S NAME: _____ PM#_____ Date: ____/_____/_____

PLEASE IDENTIFY ALL PAST and any CURRENT conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE	PROVIDED BY WHOM
INJURIES			
SURGERIES			
CHILDHOOD DISEASES			
ADULT DISEASES			

FAMILY HISTORY

1. Does anyone in your family suffer with the same condition(s)? ☐ No ☐ Yes If yes, whom? ☐ grandmother ☐ grandfather ☐ mother ☐ father ☐ sister(s) ☐ brother(s) ☐ son(s) ☐ daughter(s) Have they ever been treated for their condition? ☐ No ☐ Yes ☐ I don't know
2. Any other hereditary conditions the doctor should be aware of? ☐ No ☐ Yes: _____

SOCIAL HISTORY

1. Smoking: ☐ cigars ☐ pipe ☐ cigarettes How often? ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
2. Alcoholic Beverage: consumption occurs ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
3. Recreational Drug use: ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
4. Hobbies - Recreational Activities - Exercise Regime: How does your present problem affect? (See ADL form)

PATIENT'S NAME: _____ PM#_____ Date: ____/_____/_____

QVAS

DIRECTIONS: Fill in your problem(s)/concerns that you are currently experiencing. 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 _____

   0 1 2 3 4 5 6 7 8 9 10

2. What is your TYPICAL or AVERAGE pain?

   No Pain _____

   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 _____

   0 1 2 3 4 5 6 7 8 9 10

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

   No Pain _____

   0 1 2 3 4 5 6 7 8 9 10

Problem/ Concern #2_____

1. What is your pain RIGHT NOW?

   No Pain _____

   0 1 2 3 4 5 6 7 8 9 10

2. What is your TYPICAL or AVERAGE pain?

   No Pain _____

   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 _____

   0 1 2 3 4 5 6 7 8 9 10

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

   No Pain _____

   0 1 2 3 4 5 6 7 8 9 10

PATIENT'S NAME: _____ PM#_____ Date: ____/_____/_____

ACTIVITIES OF LIFE

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

ACTIVITIES:	EFFECT:			
Carry Children/Groceries	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Climb Stairs	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Pet Care	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Extended Computer Use	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Read/Concentrate	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Getting Dressed	□ 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
Yard work	□ 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
Driving	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Other: _____	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform

List Prescription & Non-Prescription drugs you take: _____

_____

_____

PATIENT'S NAME: _____ PM#_____ Date: ____/_____/_____

REVIEW OF SYSTEMS

Please mark: P for in the Past C for Currently have N for Never

___ Headache	___ Pregnant (Now)	___ Dizziness	___ Prostate Problems	___ Ulcers
___ Neck Pain	___ Frequent Colds/Flu	___ Loss of Balance	___ Impotence/Sexual Dysfun.	___ Heartburn
___ Jaw Pain, TMJ	___ Convulsions/Epilepsy	___ Fainting	___ Digestive Problems	___ Heart Problem
___ Shoulder Pain	___ Tremors	___ Double Vision	___ Colon Trouble	___ High Blood Pressure
___ Upper Back Pain	___ Chest Pain	___ Blurred Vision	___ Diarrhea/Constipation	___ Low Blood Pressure
___ Mid Back Pain	___ Pain w/Cough/Sneeze	___ Ringing in Ears	___ Menopausal Problems	___ Asthma
___ Low Back Pain	___ Foot or Knee Problems	___ Hearing Loss	___ Menstrual Problem	___ Difficulty Breathing
___ Hip Pain	___ Sinus/Drainage Problem	___ Depression	___ PMS	___ Lung Problems
___ Back Curvature	___ Swollen/Painful Joints	___ Irritable	___ Bed Wetting	___ Kidney Trouble
___ Scoliosis	___ Skin Problems	___ Mood Changes	___ Learning Disability	___ Gall Bladder Trouble
___ Numb/Tingling arms, hands, fingers		___ ADD/ADHD	___ Eating Disorder	___ Liver Trouble
___ Numb/Tingling legs, feet, toes		___ Allergies	___ Trouble Sleeping	___ Hepatitis (A,B,C)

_____ _____ - _____ - _____
Patient or Authorized Person's Signature Date Completed

_____ _____ - _____ - _____
Doctor's Signature Date Form Reviewed

PATIENT'S NAME: _____ PM#_____ Date: ____/_____/_____

Informed Consent

REGARDING: Chiropractic Adjustments and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often very minimal, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke-which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives, as well as the risks associated with chiropractic adjustments and all other procedures provided at Expedition Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____

Patient Name (print)

_____ ____/____/____ ☐ Witness Initials

Patient or Authorized Person's Signature Date

Expedition 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 Personal Health Information. 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:

PATIENT'S NAME: _____ PM#_____ Date: ____/_____/_____

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. Steven Barger) at 772245-6141. 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

I have received a copy of Expedition 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.

_____ _____
Patient's Name DOB

_____ _____
Patient's Signature Date

_____ _____
Witness Date