Krueger Family Chiropractic

Pregnancy Chiropractic Case History/Patient Information

****If you are a new patient, please fill out the new patient form in addition to this form****

Date:_____

Last Name:_____ First Name:_____ Middle Initial:_____

Address:_____City:_____ State:_____ Zip:_____

Home Phone:_____Cell Phone:_____

Age:_____ Birth Date:_____

Insurance Company:_____

Names/Ages of Children:_____

Name of OB/Midwife:_____ Date of Last Visit:_____

Do you see your midwife/OB regularly? Yes____ No____

When doctors work together it benefits you. May we have your permission to update the OB/midwife regarding your care at this office? (check one) Yes ____ No____

How far along in the pregnancy are you?_____weeks What is the Baby's due date?_____

How many pregnancies have you had including this one?_____

During the pregnancy have you had any of the following:

___Back Pain ___Morning sickness ___Indigestion ___Anemia

___Sciatica ___High Blood Pressure ___Difficulty Sleeping ___Diabetes

___Neck Pain ___Headaches ___Swollen Ankles ___Seizures

___Abnormal Bleeding ___ Falls/Traumas ___Breech Positioned Baby

___Other:_____

Have you had any complications (other than listed above) during this pregnancy? Yes___ No___

Have you been hospitalized for anything during this pregnancy? Yes___ No____

If you have had any pregnancy related pain, please describe:_____

_____

How long have you been experiencing pain?_____

Has the baby ever been in the breech position?_____

How many ultrasounds have been performed?_____

Do you take prenatal vitamins? Yes___ No___

Do you get regular Exercise? Yes___ No___ How often?_____

During the pregnancy, have you used any of the following:

___Tobacco ___Alcohol ___Non-prescribed drugs

___Prescription medications

Describe:_____

Previous Chiropractic Treatment? If so, when?_____

Previous pregnancy/Pregnancies

With any previous pregnancy/pregnancies was the birth:

___Normal vaginal ___Forceps ___Vacuum Extraction

___Cesarean ___Breech ___Home Birth

If you had a previous cesarean are you planning for a VBAC?___Yes ____No

Hospital Name (if applicable):_____

Labor or delivery Problems:_____

Previous Chiropractic with Pregnancy:_____

Congenital defects/anomalies:_____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to Dr. Krueger or Krueger Family Chiropractic. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____