Deep Roots Chiropractic
Pregnancy Questionnaire

DEEP ROOTS
CHIROPRACTIC

Today's Date: _______________

Name: _______________________________ **Date of Birth:** ___________ **Age:** ______

Address: _____________________________ **City:** _________________ **State:** ___ **Zip:** ______

Phone Number: _________________ **Email:** __________________

Emergency Contact: ____________________ **Emergency Contact #**: __________________

Prenatal Intake

1. Is this your first pregnancy? (circle) Yes No
   a. If not, please tell us about your previous pregnancies: _________________________
   ____
   ____
2. If this is not your first pregnancy, will you follow the same birth plan? Yes No
   a. If not, what would you like to change? _____________________________________
   ____
   ____

Conception + Early Pregnancy

3. What is your expected/calculated due date? ________________________
4. Did you have any difficulty conceiving? Yes No
   a. If yes, please explain: ____
   ____
5. Have you ever used oral/hormonal contraceptives? Yes No
   a. If yes, what kind and for how long? ____
6. What was your pre-pregnancy weight? _____________ lbs
7. What is your current weight? _________________ lbs
8. Have you experienced morning sickness? Yes No

Current Health Conditions

9. What type of exercise(s) are you currently performing? ______________________________
   ____
10. Please tell us about your current diet, and any dietary restrictions: ____________________
    ____
    ____
    ____

11. If you have taken medications or supplements, please list them and the reason for taking them: ____
    ____
    ____
    ____

12. Do you have any current health conditions that Dr. Jarod needs to know about? If yes, please explain: ____
    ____
    ____

13. Have you had any slips/falls during your pregnancy? Yes No
    a. If yes, please explain: ____
       ____

14. Have you had any major emotional/mental stressors during pregnancy? Yes No
    a. If yes, please explain: ____
       ____

Your Birth Plan

15. What are your top 3 goals for your pregnancy?
    1. ____
    2. ____
    3. ____

16. Do you currently have a birth plan? Yes No
    a. If yes, please explain: ____
       ____

17. Are you taking prenatal/birthing classes? Yes No

18. Who is your OB/GYN or Midwife? ____
    a. Will they be present for your birth? Yes No
    b. Who is your birth provider? ____

19. Do you plan on having a doula/birth coach present during delivery? Yes No

20. Do you wish to have a natural vaginal labor/delivery? Yes No
    a. If not, what concerns do you have? ____
    ____

Your Post-Birth Plan

21. Do you plan on breastfeeding? Yes No
    a. If not, please explain: ____
    ____

22. What do you intend to do regarding vaccines? ___________________________________
____
____

23. Is there anything else you'd like us to know about your pregnancy/birth plan? ________
____
____

24. What would you like to **gain** from chiropractic care during your pregnancy? __________
____
____

We are so grateful to be serving **you** during this special time in your life! It is our goal, through chiropractic care, to balance your body and nervous system so you can experience a comfortable pregnancy and delivery!

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.

Acknowledge & Initial Here: __________

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 occurring at a rate between one instance per one million to one per two 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 finding 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 the doctors at Deep Roots Chiropractic. 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. This pertains to any and ALL services rendered.

Acknowledge & Initial Here: __________

DEEP ROOTS CHIROPRACTIC PHOTO RELEASE

I grant Deep Roots Chiropractic and its employees the right to take photographs of me with connections to the promotion of chiropractic via websites, social media, and any other avenues. I agree that Deep Roots Chiropractic may use such photographs of me for any lawful purpose, including such purpose as publicity, illustration, advertising, and web content.

Acknowledge & Initial Here: __________

Doctor Use Only

I am acknowledging that I have reviewed and discussed the health history of this practice member.

Doctor Signature ____