Prenatal Intake

Information contained within this form is considered strictly confidential. Your responses are important to help us better understand your health, goals of treatment, and ensure the delivery of the best possible care and support. This form must be fully completed before you can begin your care in our office.

Given Name :_____Nickname: _____
Gender identity/pronouns: _____ Date of birth: _____ Age: _____
Address: _____
City: _____ State: _____Zip:_____
Primary phone: _____ Cell phone: _____
Email address: _____
Occupation: _____ Employer: _____
Social security number: _____ Relationship status: _____
Primary care provider: _____ Pediatric care provider (if known):_____
Who lives with you? _____
Where are you receiving your prenatal care? _____
OB or Midwife? _____ Do you plan to work with a Doula? _____
When is your estimated due date? _____ How many weeks pregnant are you? _____

May we leave you voicemails about your appointments? _____
Do you prefer to be contacted via phone, text or email? _____
How did you hear about our office? _____

Please specify who the other biological contributor of your baby is: ☐Your partner ☐ Sperm donor
How you would like us to refer to this person (donor, co-parent, father, mother, etc.) _____

Your Partner (if applicable, or alternate emergency contact)
Given Name (first, last): _____ Nickname: _____
Gender identity/pronouns: _____ Date of birth: _____ Age: _____
Cell phone: _____ Email address: _____
Occupation: _____ Employer: _____

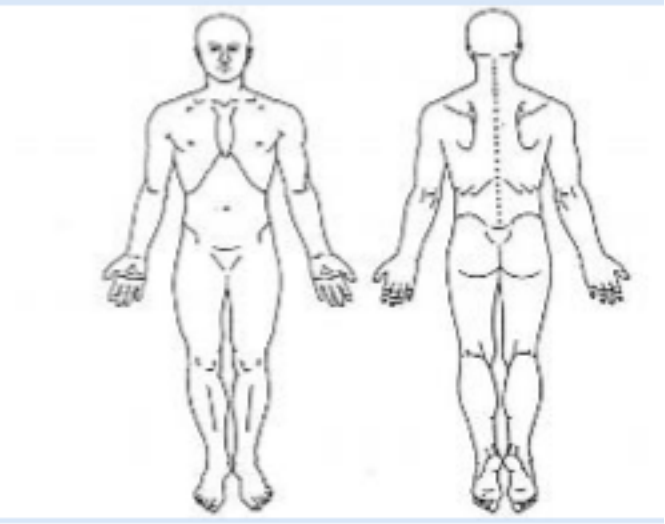
Insurance Information
Insurance company and plan name: _____
Name of policy holder: _____
Relationship to policy holder:_____
Policy holder date of birth (mm/dd/yyyy): _____
ID number: _____ Group number: _____

Please list any other providers you are working with or plan to work with:
Midwife/OB:_____ Childbirth Education Class: _____
Massage Therapist: _____ Therapist: _____
Acupuncturist: _____ Doula: _____
Prenatal Fitness (yoga, birthfit etc…) _____
Physical Therapist: _____Other:_____
If you need a referral for any of the above providers please ask!

Describe the reason for your visit today:
_____
_____

Musculoskeletal History

Please mark your symptoms on the diagram.



On a scale of 1(not intense) to 10 (you are unconscious with pain), how would you rate your symptoms:

1 2 3 4 5 6 7 8 9 10

When did your symptoms start? _____
How did your symptoms begin? _____
How often do you experience symptoms? Constantly Frequently Occasionally Intermittently
Describe your symptoms? Sharp Dull ache Numbing Burning Tingling Shooting
Other:_____
Are your symptoms? Getting better Staying the same Getting worse
What aggravates your current symptoms? _____
What positions or activities relieve your current symptoms? _____
Have you experienced these symptoms in the past? _____
How do your symptoms interfere with your daily life? _____

Have you seen a chiropractor before? _____ If yes, Doctor's name: _____
How long since last chiropractic adjustment? _____
Have you seen any other health care provider for these symptoms? _____

What are your reasons for seeking treatment in our office? (circle all that apply)

pain relief	general health & wellbeing	optimal fetal positioning
healthy pregnancy	learn homecare exercises	prepare body for easier birth
prepare body for VBAC	prepare for intervention free birth	learn spinning babies exercises

Please list any other specific goals you may have for treatment in our office (*example: to be able to decrease discomfort while sleeping, to be able to maintain exercise routine etc…):*
1._____
2._____
3._____

Do you have any specific plan/goals for your birth?_____
_____

Current Health History
What is your general state of health? _____
Do you exercise on a regular basis? _____
Do you have a specific diet? (vegetarian, gluten-free, vegan etc.)_____
Allergies (environmental, food, medications etc.):
_____

Current Medications (including over the counter):

Medication Name Purpose

1. _____ _____
2. _____ _____
3. _____ _____

Current Herbs/Supplements/Vitamins:

_____
_____
_____

Please list any conditions you have been diagnosed with and the name of the medical provider who diagnosed it. State the year of diagnosis, and any treatment received or ongoing treatment:

_____
_____
_____
_____

Surgeries and/or hospitalizations (list dates, reasons, and any complications):

_____
_____
_____

Family History: list any significant family history for your immediate family (parents, siblings, kids)

_____
_____
_____

Prenatal History

Have you ever been pregnant before? ☐ Yes ☐ No

If yes, fill out the information below:

Total # pregnancies: _____ Miscarriage: _____weeks:_____

Live births: _____ Stillborn: _____weeks:_____

Abortion: _____ # of Currently Living children: _____

Date	Place of Birth	# of weeks	Length of labor	Vaginal or cesarean	Weight	Sex and Name	Current Age

During your pregnancies or births, did you or your baby experience any of the following problems? (check all that apply)

☐ Gestational diabetes
☐ Hypertension, preeclampsia, or toxemia
☐ Breech presentation
☐ Slow or inadequate fetal growth
☐ Group B Strep positive culture
☐ Forceps or vacuum assisted birth
☐ Placental problems
☐ Induction of labor
☐ Fetal distress during labor
☐ Shoulder dystocia
☐ Newborn distress after birth
☐ Postpartum hemorrhage
☐ Breastfeeding problems
☐ Other _____

Were you pleased with your previous birth experience? Is there anything you hope goes differently for this birth?

_____
_____

Current Pregnancy

Did you use any assisted reproductive technologies to conceive? _____

If yes to the previous question, which methods did you use? (check all that apply)

☐ Medications ☐ Intrauterine insemination (IUI) ☐ In vitro fertilization (IVF)
☐ Other _____

Please list any complications associated with your current pregnancy: _____
_____

Do you any concerns, fears, or anxiety about any of the following?

☐ Nutrition
☐ Exercise
☐ Pregnancy testing, labs, and ultrasounds
☐ Fetal growth and development
☐ Childbirth preparation
☐ Parenting preparation
☐ Preparation of older children
☐ Relationship with your partner
☐ Labor & birth
☐ Other _____

How do you plan to feed your baby?

☐ Breastmilk exclusively ☐ Formula ☐ I'm not sure yet!
☐ Combination of breastmilk and formula ☐ Other
_____

Please add any other comments, thoughts, or questions you would like me to address.

_____
_____
_____
_____

Dr. Abby
PRENATAL & PEDIATRIC
CHIROPRACTOR

Required Signatures

□ I authorize use of these intake forms on all of my insurance submissions.

□ I authorize release of information to my insurance companies.

□ I understand that I am responsible for my bill.

□ I authorize my doctor to receive payment for services rendered from my insurance company.

□ I understand that there may be charges that my insurance company may not cover.

□ I understand that copays are due at time of service and that Dr. Persoleo's Office will bill me for any co-insurance or balance owed.

□ I certify that the information on all of my intake forms is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature:_____ Date:_____

Missed Appointment/Cancellation Policy

We understand that you may sometimes need to reschedule appointments. If you need to reschedule, please contact our office as soon as you know that you will not be able to keep the appointment. It is our office policy to require 24 hours advance notice for all appointment cancellations/reschedules to allow maximum availability for our patients. We welcome voicemails and emails left after hours. If you miss an appointment or cancel it with less than 24 hours notice, a missed appointment fee of $25.00 will be assessed to your account. This fee is not reimbursable by insurance and is the patients' responsibility. There is no fee for weather related cancellations.

Signature:_____ Date:_____

Informed Consent

To the patient: Please ask questions before you sign if there is anything that is unclear.

As with any healthcare procedure, there are certain complications that may arise during chiropractic adjustments and therapy. Complications may include: stiffness and soreness following the first few days of treatment, fractures, disc injuries, dislocations, muscle strain, costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke.

The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare". I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

I _____ understand the above information and consent to chiropractic care in this office under Drs. Michael and Abby Persoleo. Signature: _____ Date: _____

For Office Use Only:

Findings:

Recommended treatment plan:

Today's treatment:

Homecare:

Provider Signature:

Date: