Dr. Steve Hom, D.C.
Family Chiropractor
Phone: (760) 487-8517
451 La Veta Ave. Encinitas CA 92024
www.indigodragoncenter.com

Pregnancy Health History Form

Name: _____ Date:_____

Age: _____ Birth date: (mm/dd/yyyy) _____ Sex (circle): **M F**

Email address: _____ Phone: _____

Mailing Address: _____ City: _____ Zip Code: _____

Marital Status (circle): **S M W D** Occupation: _____

Who may we thank for referring you?_____

Previous chiropractor: _____ Last visit: _____ Reason for leaving: _____

WHY THIS FORM IS IMPORTANT: **Our focus is on assisting people to achieve excellence in health. This is a function of living a continuously more healthful life and improving your body's ability to adapt to your life choices. Completion of this form provides us with an improved understanding of your physical, emotional and chemical stresses that can overwhelm the body's general adaptive potential and contribute to other health problems. Our clear goal is to help you realize what is possible for your health. Please complete this form as thoroughly as possible and the doctor will review it with you and have the greatest chance at helping you reach your goals.**

***Information collected and discussed on this form is strictly confidential and can only be shared with your consent.**

1. Current Health Concern (if there are no current concerns and this assessment is to ensure optimum health, function and wellness tick this box) ☐

Health Concern:_____

_____

If pain is involved, rank it on a scale of 1 to 10 (1 is minimal, 10 is extreme) _____

Circle or describe its character (sharp, dull, ache, burning, tingling, throbbing, spasms, other)

_____

How long have you suffered with this problem? _____

What have you tried to get rid of this problem that DID NOT work?_____

_____

Have you become discouraged about handling this problem? _____

Does it cause problems somewhere else? (circle) **Yes No** If so, where? _____

How often does it occur? _____

What relieves? _____ What aggravates? _____

When your problem is at its worst, how does it make you feel? _____

_____

How does this problem interfere with the following areas of your life?

Work: _____

Family: _____

Hobbies: _____

Life: _____

On a scale of 1 to 10, 10 being the highest, rate your commitment in helping us solve this problem**:** _____

Other health concerns: Please note all other health concerns present or in the past.

Diseases history: (please check applicable)

□ Allergies
□ Asthma
□ Pneumonia
□ Bronchitis
□ Tonsillitis
□ Frequent Colds
□ Immune Deficiencies
□ Cancer
□ Migraines
□ Headaches
□ Difficulty Concentrating
□ Dizziness/Lightheadedness
□ Loss of balance
□ Vision changes/Eye disease
□ Epilepsy
□ Stroke
□ Numbness and tingling

□ Pinched nerve
□ Osteoporosis
□ Hernia
□ Herniated Disc
□ Osteoarthritis
□ Multiple Sclerosis
□ Parkinson's Disease
□ GI Issues
□ Constipation
□ Loose stools
□ Diabetes
□ High cholesterol
□ Hypertension
□ Heart Disease
□ Difficult digestion
□ Heartburn
□ Indigestion

□ Bloating
□ Liver disease
□ Kidney Disease
□ Appendicitis
□ Lowered Resistance
□ Fatigue
□ Fertility problems
□ Miscarriage
□ Menstrual Pain/Cramping
□ Thyroid problem
□ Prostate problems
□ Other:
_____
_____
_____
_____

2. About Your Pregnancy: (circle answer)

Is this your first pregnancy**? Yes No** Was this pregnancy planned? **Yes No**

If this is not your first, how many times have you been pregnant? _____

Have you had any complications with previous pregnancies? **Yes No** (if yes, explain)

_____

If you have had miscarriage(s), how far along in your pregnancy did it occur?

_____

What is the estimated date of delivery? _____

Who is your primary care giver for delivery? **OBGYN / GP/ Midwife**? Name: _____

What is your planned location for delivery? **Hospital / Home/ Birth Center/Other**

How do you feel about this pregnancy? _____

Have you a birth plan? **Yes No** Would you like information on creating one? **Yes No**

Any special arrangements for the birth (planned C-sec, water delivery, birth chair, squat, other)?

_____

Would you like additional information on options for birth posturing? **Yes No**

Have you had any testing (Genetic, blood, ultrasound, amniocentesis, chorionic villi sampling, other)?

Dates and reasons: _____

Are you planning on breastfeeding post-delivery? **Yes No**

Would you like further information on the advantages of breastfeeding? **Yes No**

Was you blood pressure prior to pregnancy within normal range, low or high? _____

What is your present blood pressure and when was it last checked? _____

Have you changed your diet/menu since learning of your pregnancy? **Yes No**

Would you like further information on healthy nutrition for pregnancy? **Yes No**

Have you smoked prior to or along with this pregnancy? **Yes No Quit**

Have you had alcohol during this pregnancy? **Yes No Occasionally**

Did you receive any vaccines? **Yes No** If yes, when? _____ Which ones? _____

Were you told you had a choice in receiving vaccinations? **Yes No** Would you like information on the "other side" of this issue? **Yes No**

Have you noticed:

Swelling in the arms or legs? **Yes No**

Low back pain? **Yes No** If yes, how often? _____

Upper back pain? **Yes No** If yes, how often? _____

Neck pain? **Yes No** If yes, how often? _____

Rib or chest pain? **Yes No** If yes, how often? _____

Any foot pain? **Yes No** If yes, how often? _____

Nausea or vomiting? **Yes No** Frequency and when? _____

Arm or hand numbness/tingling? **Yes No** If yes, how often? _____

Pain radiating down the leg(s)? **Yes No** If yes, how often? _____

Heart palpitations? **Yes No** If yes, how often? _____

Circle or describe its character (sharp, dull, ache, burning, tingling, throbbing, spasms, other)

_____

When did you notice it? _____ What happened? _____

What relieves? _____ What aggravates?_____

Does it radiate or cause problems elsewhere? _____

Any associated or related concerns? _____

Professionals seen for this? (name) _____

Treatment and results_____

3. Physical stresses

Any significant injuries, falls or traumas during infancy or childhood? **Yes No Unsure** (if yes please explain) _____

Any significant injuries, falls or traumas during adulthood? **Yes No Unsure** (if yes please explain)

_____

Any hospital visits? **Yes No** Have you had any surgeries, fractures, accidents? **Yes No** Explain and dates

_____

Are you in prolonged postures? (ex: repetitive work, lifting, sitting, driving) **Yes No Unsure** (if yes, please explain) _____

Any hobbies that are physically strenuous or have repetitive movements? **Yes No Unsure** (if yes, please explain) _____

What is your usual exercise routine? _____

Any fractured bones or dislocations? _____

Any vehicle accidents? **Yes No** (If yes, please explain) _____

4. Chemical Stresses

Are you taking prescription or over-the-counter medications? **Yes No (**If yes, please indicate what you are taking and why) _____

_____

Are you currently taking supplements? **Yes No** (if yes, which ones and why?)

_____

_____

Do you smoke? **Yes No Quit** (if yes how much?) _____

Do you drink alcohol? **Yes No** (if yes, roughly how much?) _____

Are you happy with your diet? **Yes No** Do you wish assistance with it? **Yes No**

Do you drink bottled water? **Yes No Occasionally**

Are you exposed to pollutants, strong smells, chemicals, aerosols? **Yes No Occasionally**

Do you eat organic? **Yes No Occasionally**

Do you use natural or environmentally friendly products in your home? I.E. Cleaning supplies, hair and makeup, etc. **Yes No** _____

Do you drink or bathe/shower in chlorinated water? **Yes No Occasionally** _____

How is your digestion? _____

5. Mental/Emotional Stresses

As psychological stress has been shown to negatively affect many systems, please let us know how you are coping with life's stresses.

If you are experiencing significant or ongoing stress please explain _____

_____

Do you practice some form of meditation, breath work, other mind-body movement or have a routine to reduce your stress? **Yes No** Explain _____

Are you interested in learning about stress reduction practices? **Yes No**

How is your sleep? _____ How much do you get per night?_____

Please check the boxes where you experience stress the most:

□ Life in General	□ Time Management	□ Physical Activity
□ Work and Career	□ Sports and Hobbies	□ Financial Stress
□ Symptom Management	□ Health and Wellbeing	□ Quality of Sleep
□ Relationships	□ Other: _____	

6. Why are you here?

People seek chiropractic care for a number of reasons and have certain expectations and perceptions. Please tick the goals which apply to you so we can accommodate your wishes.

□ Pain Reduction	□ Relief	□ Improved Quality of Life
□ Manage My Crisis	□ Information on Prevention	□ Stress Reduction
□ Symptom Management	□ Healthier Immune System	□ Keep Me Moving
□ Improved Performance	□ Full Body Integration	□ Wellness
□ Longevity	□ Optimum Function and Quality of Life	
□ Other: _____		

In 6-12 months, if you could have anything for you and your baby's health, what would you want? List 3 goals:

1. _____
2. _____
3. _____

7. Family Health History

Please note any health issues that are present with family members such as parents, siblings, significant other or children.

Condition	Father	Mother	Spouse	Siblings		Children			
	Age	Age	Age	Age	Age	Age	Age	Age	Age
ADHD									
Allergies									
Arthritis									
Asthma									
Autism									
Back Trouble									
Bed Wetting									
Bursitis									
Cancer									
Chest Pain									
Colic									
Constipation									
Crohn's Disease									
Depression									
Diabetes									
Diarrhea									
Disc Problems									
Down Syndrome									
Ear Infection									
Emotion Issues									
Emphysema									
Epilepsy									
Headaches									
Migraines									
Heartburn									
Heart Trouble									
High Blood Press									
IBS									
Indigestion									
Infertility									
Insomnia									
Kidney Trouble									
Neck Pain									
Neuritis									
Nervousness									
Pinched Nerve									
Scoliosis									
Sinus Trouble									
Other									

Our Fee Structure

Please note our office fees for your initial visit include:

Consultation	Complimentary
Examination + scans	$249.00 *(Referred Patients $149.00)*
TOTAL	**$249.00** ***(or $149.00)***

Please let us know if you, or you spouse is active duty military or veteran. As a thank you to our service members, we offer an additional 10% discount on all regular visit rates.

* Following your initial visit, subsequent family members' initial appointments are subject to the discounted rate of $109 per visit (including consultation, examination and scans).

SIGNATURE: _____ DATE: _____

(Signature of Parent/Guardian required if patient under age 18)

Thank You!

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Health Care Authorization Form

I have been provided with a copy of the Notice of Privacy Practices for Protected Health Information. The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information (PHI) that will occur in my treatment, payment of my bills or in the performance of health care operations of this chiropractic office. A copy of our notice is attached, and we encourage you to read it and request your own copy if you would like one.

This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information. I hereby give permission to Stephen M. Hom Chiropractic, INC. to use and/or disclose Protected Health Information in accordance with the following:

SPECIFIC AUTHORIZATIONS:

- I give permission to Stephen M. Hom Chiropractic, INC. to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, newsletters, information about treatment alternatives or other health related information.

- If Stephen M. Hom Chiropractic, INC. contacts me by phone, I give them permission to leave a voice mail.

- I give permission to Stephen M. Hom Chiropractic, INC. to use my photograph marketing materials such as their brochure, website, social media and ads in print media.

- I give permission to Stephen M. Hom Chiropractic, INC. to use any testimonial written by me for marketing purposes such as, sharing with other patients or potential patients, in their brochure, on their website or in ads in print media.

- I give Stephen M. Hom Chiropractic, INC. permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during care. Should I need to speak with doctor at any time in private, the doctor will provide a room for these conversations.

- By signing this form, you are giving Stephen M. Hom Chiropractic, INC. permission to use and disclose your protected health information in accordance with the directives listed above.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. This authorization will remain in effect for the duration of my care at Stephen M. Hom Chiropractic, INC. for Healthy Families plus 7 years or until revoked by me.

RIGHT TO REVOKE AUTHORIZATION:
You have the right to revoke this authorization, in writing, at any time. However, your written request to revoke this authorization is not effective to the extent that we have provided services or acted in reliance on your authorization.

You may revoke this authorization by mailing or hand delivering a written notice to the Privacy Official of Stephen M. Hom Chiropractic, INC.. The written notice must contain the following information:

1.Your name
2. Social Security number
3. Date of Birth
4. A clear statement of your intent to revoke this authorization
5. The date of your intent to revoke this authorization and your signature

The revocation is not effective until it is received by the Privacy Official.

This AUTHORIZATION is requested by Stephen M. Hom Chiropractic, INC. for its own use/disclosure of PHI. (Minimum necessary standards apply.)

I have the right to refuse to sign this **authorization**. If I refuse to sign this **authorization**, Stephen M. Hom Chiropractic, INC. will not refuse to provide treatment however, it will not be possible for Stephen M. Hom Chiropractic, INC. to file third party billing on my behalf and I will be responsible for 1) payment in full at the time services are provided to me 2) scheduling my own appointments since Stephen M. Hom Chiropractic, INC. will be unable to contact me 3) all contact with Stephen M. Hom Chiropractic, INC. regarding my care. *Additionally, any collection activity as permitted by law is not waived by refusal to sign the authorization.*

I have the right to inspect or copy, within boundaries, the protected health information to be used/disclosed. A reasonable fee for copying will apply. A copy of the signed authorization will be provided to me.

HEALTHCARE AUTHORIZATION

I have read and understand this Healthcare Authorization Form and acknowledge receipt of The Notice of Privacy Practices for Protected Health Information. My signature below represents agreement with these practices.

Patient's name (please print): _____ DOB:

Patient's Signature: _____ Today's Date: _____

Name of Personal Representative (if someone is designated to act on your behalf/or for a minor)

Parent or Personal Representative name (please print):

Signature:_____ Today's Date: _____

Description of Representative's Authority to Act on Patient's Behalf: _____

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Your Informed Consent

In order for my health professional, as indicated below, to make a determination on the suitability of my case for care, I acknowledge and understand that I must complete a thorough evaluation. I do hereby request and consent to the performance of such an evaluation by the person(s) named below, or any party authorized to do so by that person.

I have had the opportunity to discuss with the Doctor of Chiropractic indicated below, or with any party authorized to do so, by that Chiropractor, about the nature and purpose of the examination process. I understand that there may be remotely associated risks with examinations, as there are with all healthcare treatments. In healthcare, the matter of whether any treatment is appropriate or not, is determined by looking at the level of risk and comparing this with the level of expected benefit. I understand that I may ask the doctor to stop the examination at any time. I also understand that by signing this form, the Chiropractor continues to be obligated for best practices delivered in my interests.

We would like all of our new patients to understand that Chiropractor's possess the lowest malpractice insurance premiums of all the health care professions in the world. Chiropractic care maintains significantly less risk compared to traditional medical, drug and surgical care professions, which account for approximately 200,000 annual deaths in North America alone. Chiropractic is your safest option in the health care system.

Although Chiropractic is reported to be the safest health care system in the world, we feel that it is responsible to let you know:

a. *Risk of stroke is reported to be 1 in 5-8 million and the cause has yet to be determined.*
b. *While extremely rare, there have been reports of ligament sprains and even rib fractures reported.*
c. *There have been rare reports of disc injuries, although no clinical scientific study has ever demonstrated chiropractic care to be the cause.*

I have read and understand the above consent, and have had the opportunity to discuss it with my chiropractor.

I consent to the care recommended by my chiropractor and extend this consent to include all doctors of this Chiropractic & Wellness Center. This consent applies to all present and future care for my family and me.

Your Name: _____ Date: _____

Your Signature: _____

Signature of Parent or Guardian: _____