healthcarecomplete

- **Individualized Family Chiropractic Care**
- **Pediatric & Perinatal Certified**
- **Customized Nutritional Counseling**
- **Rehabilitative Exercise**

PREGNANCY HEALTH HISTORY

Name: _____ Today's Date _____

Address: _____ Business Employer: _____

City: _____ Type of Work: _____

State: _____ Zip/Postal Code: _____ Work Phone: _____

Home Phone Number: _____ Cell:_____

Date of Birth: _____ Age: __ Sex: □ M □ F Circle One: Single Married Widowed Divorced Separated

Email Address:_____ Name Of Spouse (If applicable): _____

Name of Emergency Contact: _____

Referred To This Office By: _____ Phone Number of Emergency Contact: _____

Who is Responsible For Your Bill, You and □ Spouse □ Workers' Comp □ Auto Insurance □ Medicare

□ Personal Health Insurance Co.: _____ □ Health Card Number: _____

Insured Person's Name:_____ Insured Person's Date of Birth: _____

Name of Primary Care Physician (PCP):_____

PCP Address: _____

Why are you here today? (choose 1, 2, and/or 3)

1) For advice on a particular health crisis_____

_____

2) To prevent potential health issues (include whether you have experienced it before) _____

3) To strengthen your health? _____

How would you rate your current health? (1 is poor and 10 is exceptional) 1 2 3 4 5 6 7 8 9 10

Weeks Pregnant: _____ **Estimated Due Date:** _____

Was this a planned pregnancy? Yes No **How many pregnancies have you had in the past?** _____

How many live births have you had in the past? _____

How do you feel about your pending birth? □ Frightened □ Anxious □ Excited Comments: _____

Are you currently receiving prenatal care from a midwife, obstetrician or both? _____

Name of practitioner: _____

Which hospital or birth center are you planning to have your baby? Or are you planning a home birth?_____

What type of birth are you planning: _____

Do you have a birth plan? Yes No **What is your vision for labor?**_____

_____

Do you feel supported in your birth choices (by your partner, family, health practitioners)? Yes No

Have you had any tests to guide you on health during pregnancy? Yes No **Which tests:**

_____

Have you had any ultrasounds to date? Yes No **If yes, how many?** _____ **Findings:** _____

Are you aware of the current position of your baby? (ie: head down, breech, transverse) _____

Have you received information or advice on optimal diet while pregnant? If so, what advice _____

Have you received any advice on posture during pregnancy? Is so what advice? _____

_____

Would you like further information about how to minimize exposure to toxins in our foods and personal care products? Yes No

Are you experiencing any emotional stress (ie: relationship, family, financial, career etc)? Yes No
Explain: _____
Drugs You Take Now: □ Nerve Pills □ Pain Killers/Muscle Relaxers □ Blood Pressure Medicine □ Insulin □ Other

List Medications:_____
Vitamins/Herbs/Minerals You are taking: _____
_____

PAST HEALTH HISTORY

Major Surgery/Operations: □ Appendectomy □ Tonsillectomy □ Gall Bladder □ Hernia □ Back Surgery □ Broken Bones

□ Other (please list details)_____

Major Accidents Or Falls: _____

Hospitalization (Other Than Above): _____
Previous Chiropractic Care: □ None □ Doctor's Name & Approximate Date of Last Visit: _____
Date of Last: Spinal X-ray _____ MRI _____ (region:_____) Physical Exam _____

Below is a list of diseases, which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect you overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES or SYMPTOMS YOU HAVE HAD:

- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer (type: _____)
- ☐ Heart Disease
- ☐ Thyroid
- ☐ Influenza
- ☐ Pleurisy
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorders
- ☐ Lumbago
- ☐ Eczema

Have you tested HIV Positive? ☐ Yes ☐ No

CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST SIX MONTHS:

MUSCULO-SKELETAL
- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficult Chewing/Clicking Jaw
- ☐ General Stiffness
- ☐ Gas/Bloating After Meals
- ☐ Heartburn/Reflux
- ☐ Black/Bloody Stool
- ☐ Irritable Bowel/Colitis/Chron's

NERVOUS SYSTEM
- ☐ Weakness in arms/legs/body
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Cold or discolored extremities
- ☐ Fainting
- ☐ Convulsions or Seizures
- ☐ Tingling Extremities

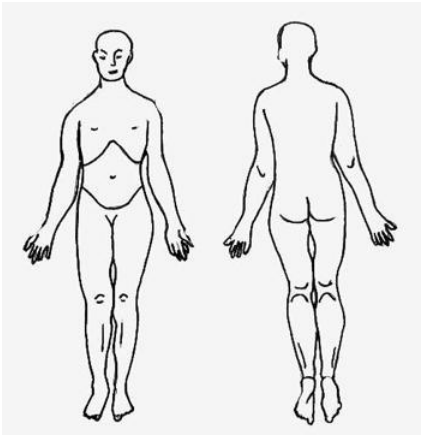
GENITO-URINARY
- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Discolored Urine
- ☐ Kidney Stones

C-V-R
- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems or congenital defect
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

EENT
- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches or Infection
- ☐ Hearing Difficulty
- ☐ Stuffed Nose or Sinus Infection
- ☐ Ringing in the ears

MENTAL/EMOTIONAL
- ☐ Anxiety
- ☐ Psychotic episodes
- ☐ Attempted suicide in lifetime
- ☐ Anger/aggression
- ☐ Attention Deficit
- ☐ Depression

Please outline on the diagram the area of your discomfort



GENERAL CODE

- ☐ Fatigue
- ☐ Allergies (List: _____)
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

GASTRO-INTESTINAL

- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps

MALE/FEMALE

- ☐ Menstrual Irregularity
- ☐ Menstrual Cramps
- ☐ Vaginal Pain/Infection
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction
- ☐ Other Problems

FAMILY HISTORY

List family members with the following illnesses:

- ☐ Heart Disease _____
- ☐ Cancer _____
- ☐ Diabetes _____
- ☐ Stroke _____
- ☐ Neurological Disorder _____
- ☐ Other _____

Height_____

Weight_____

EXERCISE

- ☐ **None**
- ☐ **Mild 1-2x/wk**
- ☐ **Moderate 3x/wk**
- ☐ **Daily**
- ☐ **Heavy (daily and intense)**

HABITS

- ☐ **Smoking Pack/day** _____
- ☐ **Alcohol Drinks/wk** _____
- ☐ **Coffee/Caffeine Cups/day** _
- ☐ **High Stress Level**

Reason _____

"GEORGE'S CEREBROVASCULAR CRANIOCERVICAL FUNCTION TEST"

Instructions: Please check the correct response.

Historical Information

- Have you ever been diagnosed or told you have any of the following?
  1. High Blood Pressure (hypertension) □ Yes □ No
  2. Hardening of the arteries (arteriosclerosis) □ Yes □ No
  3. Diabetes □ Yes □ No
  4. Heart or blood vessel diseases □ Yes □ No
  5. Bone spurs on the neck bones (cervical spondylosis) □ Yes □ No
  6. Whiplash injury (flexion-extension injury) (cervical spine) □ Yes □ No
  7. Have any of your relatives suffered a stroke? □ Yes □ No
  8. Were you ever a smoker? If yes, from _____ to _____ □ Yes □ No
  9. Do you take any medications on a regular basis? □ Yes □ No
     - If yes, what? (Coumadin, Heparin, Aspirin, Anti-hypertensive medicine, etc.)

     _____
  10. (Women Only) Have you ever taken oral Contraceptives? □ Yes □ No
     - If yes, from _____ to _____

- Have you ever had any of the following, even short, temporary attacks, in the last year?
  1. Blurred Vision □ Yes □ No
  2. Double Vision □ Yes □ No
  3. Diminished or partial loss of vision in one or both eyes? □ Yes □ No
  4. Complete loss of vision in one or both eyes? □ Yes □ No
  5. Ringing, buzzing or any noise in the ear(s)? □ Yes □ No
  6. Hearing loss in one or both ears? □ Yes □ No
  7. Slurred speech or other speech problems? □ Yes □ No
  8. Difficulty swallowing? □ Yes □ No
  9. Dizziness? □ Yes □ No
  10. Temporary lack of understanding? □ Yes □ No
  11. Loss on consciousness, even momentary blackouts? □ Yes □ No
  12. Numbness or loss of sensation in the face, fingers, hand, arms, legs, or any other parts of your body? □ Yes □ No
  13. Any other abnormal sensations in any part of your body? □ Yes □ No
  14. Weakness, clumsiness or loss of strength in the face, finger, hands, arms, or legs? □ Yes □ No
  15. Sudden collapse without loss of consciousness? □ Yes □ No

For Electronic Health Records:

☐ I choose to decline receipt of my clinical summary after every visit
(These summaries are often blank as a result of the nature and frequency of care)

healthcarecomplete

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Dr. Stephanie Rittenour, D.C., C.A.C.C.P.
260 Merrimac St.
Newburyport, MA 01950
978-499-WELL (9355)

Release of Patient Information

Patient Name (print) _____ Date of Birth: _____

Authorized Release of Records to Primary Care Physician

I hereby authorize Healthcare Complete to release health care information regarding my treatment to the PCP listed below. I understand that records may be released while I am under care per my request to my PCP.

Primary Care Provider Information

Doctor Name/Practice Name _____
Address _____
City _____ State _____ Zip _____
Phone _____ Fax _____

Patient Signature_____

Authorized Release of Medical Records from other Providers

I hereby authorize Healthcare Complete to obtain any of the following medical records from my previous or concurrent medical providers: X-ray, MRI, CT films and reports, SOAP notes, prescriptions, lab tests and any other necessary medical records.

I hereby authorize the following medical facilities to release medical information pertinent to the management of my health.

Doctor Name/Facility Name _____
Address _____
City _____ State _____ Zip _____
Phone _____ Fax _____

Patient Signature_____

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Webster Technique Agreement

□ I acknowledge that the Webster Technique is a specific chiropractic analysis and diversified adjustment. The goal of the adjustment is to reduce the effects of sacral/pelvic subluxation and/or SI joint dysfunction. In doing so neuro-biomechanical function in the pelvis is improved.

□ I acknowledge that in a theoretical and clinical framework of the Webster Technique in the care of pregnant women, sacral subluxation may contribute to difficult labor for the mother (i.e., dystocia). Difficult labor is caused by inadequate uterine function, pelvic contraction, and baby mal-presentation. The correction of sacral subluxation may have a positive effect on the causes of difficult labor.

□ I acknowledge that sacral misalignment may contribute to these primary causes of difficult labor via uterine nerve interference, pelvic misalignment and the tightening of specific pelvic muscles and ligaments. The resulting tense muscles and ligaments and their abnormal effect on the uterus may prevent the baby from comfortably assuming the best possible position for birth.

□ I understand that this sacral/pelvic analysis and adjustment may be used on all weight bearing spines: male, female, pregnant or not pregnant.

□ I acknowledge that this is not a breech turning or in utero-constraint technique

By signing this form, I understand the purpose of the Webster Technique and I agree to have the doctor perform the technique on me at her discretion.

Name _____ Date _____

CREDIT CARD PREAUTHORIZATION

Healthcare Complete
260 Merrimac Street-The Towle Building
Newburyport, MA 01950
978-499-WELL (9355)

To better serve our patients, and to give the best care to everyone, we are requiring a credit/debit card to be kept confidentially in each individual's file. Please complete the information below:

Patient Name: _____

I authorize Healthcare Complete to charge my credit card account for patient care under the following circumstances (check off each one that you authorize):

- ☐ Please charge my credit card weekly in pre-payment of my appointments
- ☐ Please charge my credit card after each visit
- ☐ My bill is over 90 days past due, and an attempt to reach me by phone or mail has been made, without response.
- ☐ My insurance didn't cover a service I received, and an attempt to reach me by phone or mail has been made, without response.