Boulder Women's Chiropractic
Extra Prenatal Forms

Dr. Amanda Simone, B.S., D.C.
737 29th St, Ste 200C Boulder CO 80303
www.BoulderWomensChiro.com

Note: Please complete General Intake forms in addition to these Prenatal Pages

Name: _____ **Date:** _____

Is this your first pregnancy? **Yes / No** How many weeks pregnant are you now? _____

How many other births have you had? _____ *Please complete the attached "Previous Birth History" Form.*

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

_____

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

Was this pregnancy planned? **Yes / No** How do you feel about this pregnancy? _____

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**

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? _____

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

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

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** _____

Birth Plans and Providers:

Who is your birth care provider? _____

Will you have someone with you at birth for support (other than birth care provider)? **Yes / No**

If yes, please describe: _____

Where do you plan on delivering? _____

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

Have you had any evaluation procedures (ultrasound, amniocentesis, chorionic villus sampling)?
Yes / No *If yes, please list dates, frequency and reasons:*

_____

_____

Please additionally mark any conditions you have currently or have had in the past:

_____ Uterine fibroids _____ Endometriosis _____ PCOS _____ Abnormal Bleeding

_____ Epilepsy/Stroke _____ Low/High blood pressure _____ Diabetes (Type I/II)

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Previous Birth History (if applicable): **Baby's name: _____ DOB: _____**

Place of birth: ___ Home ___ Birthing center ___ Hospital

Delivering Practitioner: ___ Lay Midwife ___ Nurse Midwife ___ OB/Gyn

Position of Delivery: ___ Squatting ___ Lithotomy position (on back with feet up)

___ On Your Side ___ Kneeling Other _____

Was labor induced/Pitocin? Yes No Unknown

Did your care provider rupture your membranes? Yes No Unknown

Were contractions stimulated intravenously with Pitocin *once* labor started?
Yes No Unknown

Did you receive any pain medications or anesthesia? Yes No Unknown

If yes, please specify type used _____

Did you receive an epidural? Yes No Unknown

Did you experience back pain during labor? Yes No Unknown

Did you deliver vaginally? Yes No

Baby presentation at time of delivery: ___ Normal ___ Posterior ___ Brow
___ Facial ___ Breech

If breech, specify type: ___Footling ___ Frank ___ Complete ___ Kneeling

Did your care provider assist delivery with his/her hands? Yes No Unknown

Was there any turning of the neck, or traction (pulling) applied to baby's neck?
Yes No Unknown

Were operative devices used to facilitate the birth? Yes No Unknown

If yes, which type? ___ Forceps ___ Vacuum Extraction

Was there any visible injury to your baby? Yes No Unknown

If so, where on your baby was the injury sustained? _____

Was there a birthing coach present? ___ Husband ___ Doula ___Friend Other _____

At what week of pregnancy was your baby born? _____

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General Intake Form

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Name: _____ Date: _____
Address: _____ City: _____ State: _____ Zip: _____
DOB: ___/___/_____ Age: _____ Gender: Male / Female / Nonbinary / _____
Preferred pronouns: (circle) She/Her/Hers He/Him/His Ze/Zir/Zim _____
Best Phone #: _____ Email: _____
Emergency Contact: _____ Relation: _____Phone: _____
How did you hear about us? _____

Previous Chiro Care: Who was your previous chiropractor? _____
Last session date (guess): _____ Reason for changing offices: _____
How often do you feel your body likes to get adjusted? _____

Health Concerns:_____
If pain is involved, please rank it from1 to 10 (1 is minimal, 10 is extreme):

1 2 3 4 5 6 7 8 9 10

Please describe its sensation (ex: sharp, dull, ache, burning, tingling, throbbing, spasms)

_____
When did you start to notice it?_____
How often does it occur?_____
Does anything relieve it ?_____
Does anything aggravate it?_____
Does it radiate or cause problems somewhere else? _____
Have you seen any other professionals for this issue? If so, what were the results?

_____

How can we best help you?

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

- ❑ Quick Fix/ Short term relief
- ❑ Fix the underlying problem/ longterm care
- ❑ Prevention to keep me healthy
- ❑ Maintenance to keep me feeling my best
- ❑ Other: _____

Contributing Factors: Physical stressors

Any significant injuries, falls or traumas during your lifetime? _____

_____

Any hospital visits/ surgeries, fractures, accidents? _____

_____

Are you in prolonged postures (ex: sitting, standing, bending, lifting, leaning over a desk):

_____

Any hobbies that are physically strenuous or have repetitive movements? _____

_____

Any vehicle accidents? What happened and when? _____

_____

Lifestyle and Habits:

What are your favorite exercise hobbies? _____

How often do you play/do your hobby? _____

How many hours of sleep do you get each night? _____ on the weekend? _____

Do you have trouble falling/staying asleep? _____

What position(s) do you sleep? (Back, side, stomach): _____

How many ounces/bottles of water do you drink per day? _____

Do you drink alcohol, and if so how much/week? _____

Do you use cannabis, and if so how much/week?_____

Current Solutions in place:

Are you taking any supplements? _____

_____

Any prescription medications? _____

_____

Additional Health History: Please check all other health concerns present or in the past.

- ❑ Asthma
- ❑ Appendicitis
- ❑ Bleeding Disorders
- ❑ Cancer
- ❑ Chronic fatigue
- ❑ Concussion/ head injury
- ❑ Diabetes (Type _____)
- ❑ Disc herniation
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Fertility problems
- ❑ Frequent infections
- ❑ High/Low blood pressure
- ❑ Heart disease
- ❑ Hepatitis
- ❑ Hernia
- ❑ High cholesterol
- ❑ HIV / AIDS
- ❑ Hypoglycemia
- ❑ Liver problems
- ❑ Kidney problems
- ❑ Multiple Sclerosis
- ❑ Neurological Issues
- ❑ Osteoarthritis
- ❑ Osteoporosis/Osteopenia
- ❑ Parkinson's disease
- ❑ Pinched nerve
- ❑ Prostate problems
- ❑ Rheumatoid arthritis
- ❑ Sinus problems
- ❑ Stroke
- ❑ Sudden weight loss
- ❑ Thyroid problems
- ❑ Tinnitus
- ❑ Ulcerative colitis
- ❑ Vision problems

❑ Other:_____

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. Please check the box if you feel stress due to each area:

- ❑ Life in general
- ❑ My Finances
- ❑ My Health
- ❑ My Work/Career
- ❑ Having enough time
- ❑ Not enough relaxation
- ❑ Quality of sleep
- ❑ My Relationships
- ❑ Lack of Self Care

Please list the top 3 sources of your stress: _____

_____

What methods do you use to reduce stress? _____

_____

Do you feel, in general, that things are getting better, worse, or staying the same?

_____

Is there anything else about your health or wellbeing you would like the doctor to know?

_____

_____

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HIPAA Consent For Care

I,_____, herby grant permission to all providers at Boulder Women's Chiropractic located at 737 29th St, Ste 200C Boulder, CO 80303 to perform examinations and therapeutic treatments. I understand that my record will be kept confidential and will not be released to others unless they are involved in my care plan. I understand that no part of my treatment or any conversations I have with the doctor or staff may be repeated without my consent. I understand that I may look at my records at anytime and I can request a copy of it. I am not being forced by anyone to accept medical treatment. I understand that a full copy of the HIPAA guidelines is available for me to view if I so choose, and that I have the right at any time to request such a document to be sent to me in the method I prefer.

Consent for examination

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 Dr. Amanda Simone, BS, DC.

I have had the opportunity to discuss with the Doctor of Chiropractic about the nature and purpose of the examination process. I understand that there may be remotely associated risks with examinations, as there are with any and 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.

Patient agreements: Please check the box next to each statement with which you agree:

- ❑ The information provided to this office is up to date and correct to the best of my knowledge.
- ❑ I take responsibility for payment for any services rendered to me by Boulder Women's Chiropractic. I understand that best attempts will be made to bill my insurance (if benefits apply) but that ultimately I am the one who is financially responsible for my care.
- ❑ I consent to receiving office correspondence emails including newsletters, promotions and updates.

Name: _____ Signature: _____ Date: _____

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Payment Agreement and Session Cancellation Terms

I understand that payment is due in full at the time of service. I assume full responsibility for and agree to pay charges for services rendered by Dr. Amanda Simone of Boulder Women's Chiropractic. I understand that my insurance benefits are subject to change as per my insurance company and my unique benefits package. I understand that I may be responsible for my entire deductible before any insurance payments will be released from my insurance company.

Cancellation Notice
Kindly give 24 hours notice of cancellation. Any appointment reserved for you or your child cannot be given to another patient as this time is marked your use only. Cancellations that occur with less than 24 hours notice are subjected to a 100% cancellation fee for the FULL COST of the session. If you are attempting to bill insurance, please note– insurance cannot be billed for sessions where you are not present, so in the event of a 24 hour cancellation fee, THE FULL AMOUNT of the session fee will be billed to your card on file, NOT your Copay.

Extenuating circumstances include, but are not limited to: going into labor, death in the family, extreme illness and others as it is deemed appropriate. Please be courteous and inform your doctor if any of these circumstances occur.

Credit Card on File
I understand that in the event I do not provide at least 24 hours notice in advance of my appointment that I will be charged a fee not to exceed 100% of the cost of my session to the credit card I provide on file.

Rescheduling Your Appointments
Moving your appointment time is very easy to do using the online scheduling system (Acuity). Please visit boulderwomenschiro.com to create and modify appointments, or click on the "cancel/reschedule appointment" link at the bottom of your email reminder. Please let your doctor know if you need assistance in understanding this online scheduling system.

Please note that if you need to reschedule within the final 24 hour window, the online system will not allow modification and you will need to contact your doctor directly, either at (303) 374-4856 or at amanda@boulderwomenschiro.com via email, text or voicemail.

I understand that email or text reminders are a courtesy and that I am ultimately responsible for my appointment.

Name: _____ Signature: _____ Date: _____