PREGNANCY CONFIDENTIAL PATIENT CASE HISTORY

(PLEASE PRINT)

Miss/Mrs/Ms Name: ____ Date: ________________

Address: ____________________________ Town/Suburb: ________________ Postcode: ________

Telephone – Home: _____________ Business: ______________ Mobile: ______________________

Email address: ____

Date of Birth: ____________Occupation: ____

Spouse's/Partners name: _____________________Exercise/Sports ____________________________

No. and ages of children ____

How many of your immediate family members attend our clinic? _______________________________

How did you hear about our clinic?

Friend or acquaintance Name: ____

Family member Name: ____

Another health professional Name: ____

Work Colleague Name: ____

Other ____

What is your main reason for attending the practice? ____

____

Have you ever received Chiropractic care? Y N if yes, when was your last visit____________

Ob/Gyn/Doula/Midwife Details ____

I am planning on a delivering: In a Hospital At a Birthing Centre Home _______________

How many weeks pregnant are you? ____

Have you been pregnant before? Y N *If Yes was the delivery* Vaginal Caesarean Section

Have you had any miscarriages? Y N *If Yes how many* ____________________________

Have you had any of the following this pregnancy:

High Blood Pressure Depression Thyroid problems
Gestational Diabetes Haemorrhoids

Have you had any alcohol or cigarettes during this pregnancy? Y N

Have you ever had any majors accidents, been in hospital or had any major surgery or illness? If so, please explain: ____

____

Are you taking any medication or supplements? Y N ______________________

Have you had this, or a similar complaint/s in the past? Y N

Do you feel any pain? Y N

If so, what type of pain? ☐ Sharp ☐ Dull ☐ Burning ☐ Constant ☐ intermittent

What aggravates your complaint? ____

Have you had any other treatment for this condition? Y N If yes please explain

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____

If relevant for your problem, please mark on the diagram below where your complaint areas are:

Have you noticed any of the following:

Swelling in arms or legs
Lower Back Pain
Upper Back pain
Neck Pain

Pubis/ Groin Pain
Headaches or Migraines
Reflux or Indigestion
Constipation

Rib or Chest pain
Nausea
Dizziness or Light-headedness
Poor Bladder Control

I Give **CONSENT** for NeuroBalance Chiropractic to liaise with my other health care professionals so that they may serve me best Y N

I would like further information on the following:

Pregnancy Exercise Classes	Birth Planning	VBAC
Pregnancy supplements	Pregnancy Acupuncture	Diet and food
Calm Birth	Paediatric Chiropractic	Pregnancy Massage
Hypno Birth	Doula Services	other______

PRIVACY POLICY STATEMENT

In accordance with the new Privacy Act, all information relative to your case is held in total confidence. However, your consent is necessary to allow us to exchange information between chiropractors within this clinic. Also when appropriate, relevant information regarding your case may be sent to other medical and healthcare practitioners for the proper and effective management of your condition.

PATIENT INFORMATION

Policies on Fees, Guarantees, Disclosed Information & Research:

1) I understand that appointments not attended or cancelled with less than 24 hours notice may incur a charge and that payment is required at the time of consultation. I will also discuss any consultation fees with a health practitioner or staff member at this clinic prior to the service being provided.
2) I appreciate that **positive results of any treatment** that I receive at NeuroBalance Chiropractic **is not guaranteed**.
3) I have disclosed any past or current illness, surgery, previous trauma, medications, drug use and any known health risks in the forms and questionnaires provided, and **agree to provide any related new information** during the period of care at this clinic or by practitioners who have assessed or treated me at this clinic.
4) Information gained from the initial assessment and follow up sessions **may be used for internal research purposes** or **publishable research** to help establish improved assessment and treatment protocols and promote a greater understanding of this field of healthcare in the scientific community. No personal details (name, contact details etc.) will be disclosed in any published material.

Risks of Care & Consent for Care:

5) Chiropractic and other techniques used at this clinic are well recognized as being extremely safe health care interventions for people of all ages. However, as with all health care disciplines there is a **risk of complications.** This may include soreness; muscle, bone or joint injury; worsening of symptoms; vision, hearing or balance problems; stroke (estimated at less than 1 per million); or side-effects caused by the use of nutritional or herbal products that may be recommended. **If I have any concerns I will discuss them prior to treatment** or during the course of a treatment program if any new concerns arise.
6) I understand that the abovementioned risks of treatment exist. However, **I do not expect the practitioner to be able to anticipate all potential risks and complications** associated with the proposed care.
7) I hereby acknowledge my consent to undergo assessments and treatment at this clinic and understand that I may withdraw my consent at anytime.

By signing below, I acknowledge that I have carefully read all of the above information and that I understand and agree to each point that is made.

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Signature **Date**