



## FEMALE NEW MEMBER HEALTH SURVEY

Name \_\_\_\_\_ Sex: ☐ M ☐ F DOB \_\_\_/\_\_\_/\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ zip \_\_\_\_\_

E-mail \_\_\_\_\_@\_\_\_\_\_.com Phone \_\_\_\_\_

Partner's Name \_\_\_\_\_ Sex: ☐ M ☐ F Phone \_\_\_\_\_

Names of Child(ren) & Age(s) \_\_\_\_\_

How did you find our office? \_\_\_\_\_

***Your genes are not your destiny; your environment determines what genes are turned on and how they express. Your biography becomes your biology.***

*We are going to ask you a variety of questions that give us more information about your past and present experiences. These experiences affect your physiology and directly affect your physical, mental, emotional and spiritual wellbeing. These experiences fall into three categories; physical (trauma), mental/emotional/spiritual (thoughts) and chemical (toxins). If this experience was too much for your system to handle it locks down as a tonal shift (tension) which can lead to a variety of symptoms. Please fill the form out to the best of your ability. Your health survey is a key to the puzzle. No detail is too small.*

**YOUR ARRIVAL** - *Your story starts with your conception, gestation and most importantly, your birth. The birth process can be very stressful on mom but also on baby.*

While in utero did your mother: ☐ Drink ☐ Smoke ☐ On Medication ☐ Use Drugs ☐ High stress ☐ Accident

Was your birth: ☐ Vaginal without assistance ☐ Vaginal with Assistance ( ☐ Forceps ☐ Vacuum Extraction

☐ C- Section ☐ Induced labor ☐ Medications given \_\_\_\_\_

Where were you born? \_\_\_\_\_

Any complications? \_\_\_\_\_

**PHYSICAL-** *Thinking all the way back to your childhood have you had any of the following?*

Surgery (& year performed) : \_\_\_\_\_

Accidents: \_\_\_\_\_

Falls: \_\_\_\_\_

Sports (past & present): \_\_\_\_\_

Duties/Habits: ☐ Sit more than an hour ☐ Carry equipment or tools on your body ☐ Repetitive bend or twist

☐ Cradle the phone to ear L or R ☐ Drive on the Job ☐ Lift more than 10 lbs. repeatedly

Number of Previous Pregnancies: \_\_\_\_\_ Have you had a miscarriage or abortion? ☐ Y ☐ N

Type of birth: ☐ Vaginal ☐ Vaginal forceps ☐ Vacuum ☐ Cesarean (☐ ER or ☐ planned)

Please mark Intervention : ☐ Induction ☐ Medication ☐ Antibiotics ☐ Epidural ☐ Ruptured membranes ☐ IV

☐ Ptoicin ☐ Episiotomy ☐ Assisted pushing Results? \_\_\_\_\_

Did You: ☐ Delay Cord Clamp ☐ Skin to Skin right away ☐ Hemorrhage ☐ Baby was separated for \_\_\_\_\_ time

☐ Complications with baby after birth ☐ Difficulty Delivering Placenta ☐ Baby latched right after birth Delivery

☐ Tearing ☐ Slow recovery ☐ Postpartum Blues ☐ Breastfeed How Long? \_\_\_\_\_

Explain: \_\_\_\_\_

How long did you labor at home? \_\_\_\_\_ Hours Laboring \_\_\_\_\_ Time pushing \_\_\_\_\_

Please provide a timeline of laboring/birthing & also note dilation at state: \_\_\_\_\_

Are you: ☐ Consciously Pre-Conceiving ☐ Conceiving ☐ Pregnant Guess (due) Date: \_\_\_\_\_

Conscious Conception? ☐ Y ☐ N Fertility Issues? ☐ Y ☐ N Fertility Measures Taken? ☐ Y ☐ N

Third trimester presentation: ☐ Head Down ☐ Transverse Lie ☐ Breech

Do you have: ☐ OBGYN ☐ Midwife ☐ Doula ☐ Lactation Consultant ☐ Postpartum Doula/ Baby Nurse

Have you experienced any of the following during this pregnancy: ☐ Morning Sickness/Vomiting/Nausea

☐ Sciatic Pain ☐ Heartburn ☐ Bladder/ Kidney Infection ☐ Difficulty Sleeping ☐ Constipation

☐ Low back Pain ☐ Headaches ☐ Pregnant with Multiples ☐ Gestational Diabetes ☐ Indigestion

☐ Pubic bone Pain ☐ Pre-Eclampsia ☐ Placental Dysfunction ☐ High Blood Pressure

### **CHEMICAL STRESS-** *Anything you inhale, ingest or absorb*

Are you currently taking/ have you taken birth control? How long? Type? \_\_\_\_\_

Current Medications (Name, Dose & Taken Since) : \_\_\_\_\_

Previous Medications (Name & When/ how long taken) \_\_\_\_\_

Rounds of Antibiotics \_\_\_\_\_

Do You: ☐ Drink Alcohol \_\_\_\_\_x/ week ☐ Use Drugs ☐ Smoke \_\_\_\_\_packs/ week

☐ Drink Soda \_\_\_\_\_x/week ☐ Eat Packaged Food ☐ Use Air Purifier

☐ Sugar in Coffee ☐ Eat Organic \_\_\_\_\_% ☐ Use Water Filter

☐ Sugar in Coffee ☐ Eat Non GMO ☐ Use Shower Filter

☐ Drink \_\_\_\_\_oz of water per day

Current Diet: ☐ Vegetarian ☐ Pescatarian ☐ Vegan ☐ Keto ☐ Paleo ☐ Dairy-free ☐ Soy-Free ☐ Gluten-Free

☐ Other ☐ Chicken ☐ Fish \_\_\_\_\_x/ week ☐ Red Meat \_\_\_\_\_x/ week

What do your typical meals look like?

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

### **EMOTIONAL/MENTAL STRESS:** These stresses have a major affect on how our body processes and feels.

Occupation \_\_\_\_\_ Do you enjoy what you do: ☐ Y ☐ N

Have you ever experienced the following?

☐ Mental Abuse ☐ Physical Abuse ☐ Sexual Abuse ☐ Major move ☐ Loss of a loved one

☐ Rapid life change ☐ Career change ☐ Being far from family/friends ☐ Financial Concern

☐ Divorce/ Separation ☐ Loss of Child ☐ Care provider for child/children ☐ Care Provider for parent

### **CURRENT HEALTH CONCERNS**

What is the reason for this reservation? \_\_\_\_\_

When did this begin? \_\_\_\_\_ Have you had this before? \_\_\_\_\_

Why do you think this is occurring? \_\_\_\_\_

Is there any other issue/secondary condition that you believe is related to this? \_\_\_\_\_

Have you gotten any other advice or treatment for this issue? (if yes than from who and what was result)

What activities aggravate your condition? \_\_\_\_\_

What activities relieve your condition? \_\_\_\_\_

Is the condition worse during certain times of the day? ☐ Y ☐ N If yes, when? \_\_\_\_\_

Does it affect: ☐ Mood, patience, attitude ☐ Sleep ☐ exercise or play ☐ day-to-day activities ☐ Ability to work  
☐ decision making ☐ relationship or intimacy

What are your healthcare goals? \_\_\_\_\_

**SECONDARY CONDITIONS-** Please mark any secondary condition (symptom/diagnosis) that you currently have or have had in the past. Secondary conditions are a result of your body compensating or adapting to your environment.

Past	Now
<input type="checkbox"/>	<input type="checkbox"/> ADD/ADHD
<input type="checkbox"/>	<input type="checkbox"/> Anemia
<input type="checkbox"/>	<input type="checkbox"/> Asthma/ Respiratory Issues
<input type="checkbox"/>	<input type="checkbox"/> Arthritis
<input type="checkbox"/>	<input type="checkbox"/> Athletic Injuries
<input type="checkbox"/>	<input type="checkbox"/> Back Pain
<input type="checkbox"/>	<input type="checkbox"/> Bowel/Bladder Changes
<input type="checkbox"/>	<input type="checkbox"/> Cancer
<input type="checkbox"/>	<input type="checkbox"/> Concussion/ Head Injury
<input type="checkbox"/>	<input type="checkbox"/> Dental/Jaw issues
<input type="checkbox"/>	<input type="checkbox"/> Depression
<input type="checkbox"/>	<input type="checkbox"/> Diabetes
<input type="checkbox"/>	<input type="checkbox"/> Digestive Issues
<input type="checkbox"/>	<input type="checkbox"/> Dizziness/Vertigo
<input type="checkbox"/>	<input type="checkbox"/> Ear/Hearing Issues
<input type="checkbox"/>	<input type="checkbox"/> Eye/Vision Issues
<input type="checkbox"/>	<input type="checkbox"/> Frequent Cold/Flu
<input type="checkbox"/>	<input type="checkbox"/> Fatigue
<input type="checkbox"/>	<input type="checkbox"/> Frequent Cold/Flu

Past	Now
<input type="checkbox"/>	<input type="checkbox"/> Headaches
<input type="checkbox"/>	<input type="checkbox"/> Herniated Disc
<input type="checkbox"/>	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/> Insomnia
<input type="checkbox"/>	<input type="checkbox"/> Mastitis
<input type="checkbox"/>	<input type="checkbox"/> Menstrual Problems/Pain
<input type="checkbox"/>	<input type="checkbox"/> Multiple Sclerosis
<input type="checkbox"/>	<input type="checkbox"/> Neck Pain
<input type="checkbox"/>	<input type="checkbox"/> Numbness/Tingling
<input type="checkbox"/>	<input type="checkbox"/> Reproductive Organ Issue
<input type="checkbox"/>	<input type="checkbox"/> Scoliosis
<input type="checkbox"/>	<input type="checkbox"/> Skin Condition
<input type="checkbox"/>	<input type="checkbox"/> Sinus Problem/ Allergies
<input type="checkbox"/>	<input type="checkbox"/> Stroke
<input type="checkbox"/>	<input type="checkbox"/> Surgery
<input type="checkbox"/>	<input type="checkbox"/> Thyroid Disorder
<input type="checkbox"/>	<input type="checkbox"/> TMJ
<input type="checkbox"/>	<input type="checkbox"/> Urinary Tract Infections
<input type="checkbox"/>	<input type="checkbox"/> Weight Changes
<input type="checkbox"/>	<input type="checkbox"/> Other _____

**YOUR HEALTHCARE TEAM (PRIMARY CARE, THERAPISTS, SPECIALISTS ECT)**

Provider Name	Provider Type	Last Visit	Reason	Result
_____				
_____				
_____				
_____				

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_  
Entered into Computer \_\_\_\_\_ initial \_\_\_\_\_

## 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 Flower of Life Chiropractic to use and/or disclose Protected Health Information in accordance with the following:

### **SPECIFIC AUTHORIZATIONS: (please initial)**

\_\_\_\_ I give permission to Flower of Life Chiropractic 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 Flower of Life Chiropractic contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.

\_\_\_\_ I give permission to Flower of Life Chiropractic 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 Flower of Life Chiropractic permission to treat me in an open room where other patients are also being treated. I am aware that other persons may overhear some of my protected health information during the course of care.

By signing this form you are giving Flower of Life Chiropractic 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 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 Flower of Life Chiropractic 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 taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of Flower of Life Chiropractic. The written notice must contain the following information:

- Your name, Social Security number and date of birth;
- A clear statement of your intent to revoke this AUTHORIZATION;
- The date of your request; and
- Your signature.

The revocation is not effective until it is received by the Privacy Official. This AUTHORIZATION is requested by Flower of Life Chiropractic 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, Flower of Life Chiropractic will not refuse to provide treatment however, it will not be possible for Flower of Life Chiropractic 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 Flower of Life Chiropractic will be unable to contact me 3) all contact with Flower of Life Chiropractic 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.

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): \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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## Informed Consent

We encourage and support a **shared decision making process** between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgeably give or withhold your consent.

**Chiropractic** is based on the science that concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

**Adjustments** are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. **Vertebral subluxation** is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, and specialized instrumentation.

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. In addition, physiotherapy or rehabilitative procedures may be included in the management protocol. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. In addition there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

**I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.**

**I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE FLOWER OF LIFE CHIROPRACTIC TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT. DATED THIS \_\_\_\_\_ DAY OF \_\_\_\_\_, 20\_\_\_\_**

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Patient Signature

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Doctor's Signature