24610 Highway 17
Waynesville, MO 65583

Ph: 573-774-4177
Fax: 573-774-3921

Pregnant Patient Questionnaire

1. CONFIDENTIAL PATIENT INFORMATION: 1

First Name: ______ Last Name: ______ DOB: ______ Gender: 1 M F

SSN: ______ Marital Status: r Single r Married r Divorced r Widowed

# of Children: ______ Occupation:

Street Address: ______ Apt.JUnit #: ______ City: ______ State: ______ Zip Code: ______

Height: ______ Weight: ______ Email: ______

Cell Phone: ______ Other Phone: ______

2. Emergency Contact: ______ Emergency Relation: ______ Emergency Phone:

3. How did you hear about us? (please select all that apply & list who in the box that appears)

r Current Patient (list who) ______
r Professional Referral/Doctor (list who) ______
r Google Search ______
r Facebook ______
r Community Partner (list who) ______
r Other (specify) ______

4. Who is your primary care physician? ______

Date of your last visit: ______

Reason for your last doctor's visit: ______

5. Are you also receiving care from any other health professionals?

r Yes r No

If yes, please name them and their specialty:

	Name	Specialty
1		
2		
3		

6. Please note any significant family medical history:

____

____

____

____

CURRENT HEALTH CONDITIONS

7. What health condition(s) bring you into our office?

____

____

____

____

Have you received care for this problem before?

r Yes r No

8. If yes, please describe the type of care.

____

____

____

____

9. When did the conditions first begin? ______________________________

10. How did the problem start?

r Suddenly r Gradually r Post-Injury

Is this condition:

r Getting worse r Improving r Intermittent r Constant r Unsure

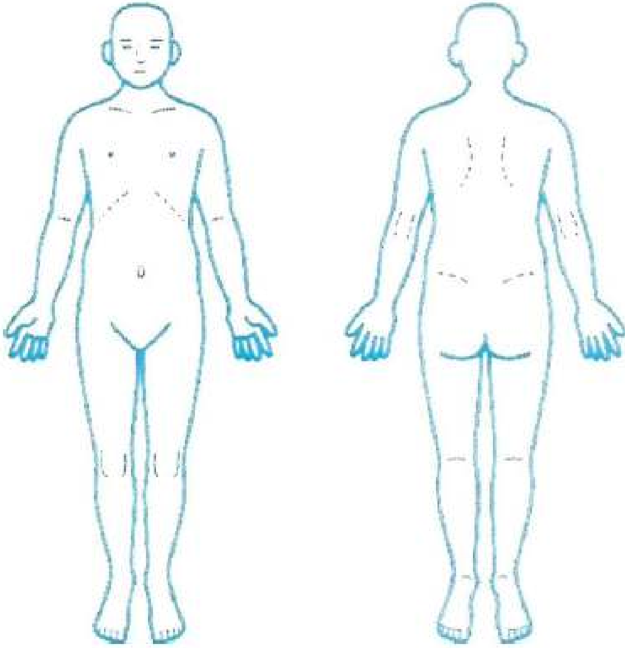
What makes the problem better?

____

What makes the problem worse?

____

11 Please indicate where you are experiencing pain or discomfort.



YOUR HEALTH GOALS

12 Your top three health goals:

1.

____

____

2.

____

____

3.

____

____

CHIROPRACTIC HISTORY

13 What would you like to gain from chiropractic care?

r Resolve existing challenge r Overall wellness r Both

14 Have you ever visited a chiropractor?

r Yes r No

If yes, what is their name? ____

15. What is their specialty?

- r Pain Relief
- r Subluxation-based
- r Physical Therapy & Rehab
- r Other
- r Nutritional

If other, specify:

____

15 Do you have any health concerns for other family members today?

____

____

____

____

TRAUMAS: Physical Injury History

16 Have you ever had any signicant falls, surgeries or other injuries as an adult?

r Yes r No

17 If yes, please explain:

____

18 Notable childhood injuries?

r Yes r No

19 If yes, please explain: ______________________________

____

____

20 Youth or college sports?

r Yes r No

If yes, list major injuries:

____

21 Any auto accidents?

r Yes r No

22 If yes, please explain:

____

____

23 Exercise Frequency?

r None r 1-2x per week r 3-4x per week r Daily

What types of exercise?

____

24 How do you normally sleep?

r Back r Side r Stomach

Do you wake up:

r Refreshed and ready r Stiff and tired

25 Do you commute to work?

r Yes r No

If yes, how many minutes per day?

____

26 List any problems with flexibility (ex. Putting on shoes/socks, etc.):

____

____

____

____

27 How many hours per day do you typically spend sitting at a desk or on a computer, tablet or phone?

____

TOXINS: Chemical & Environmental Exposure

28 Please rate your CONSUMPTION for each:

	1 - None	2	3 - Moderate	4	5 - High
Alcohol					
Water					
Sugar					
Dairy					
Gluten					
Processed Foods					
Artificial Sweeteners					
Sugary Drinks					
Cigarettes					
Recreational Drugs					

29 Are you taking any medications?

r Yes r No

30. If yes, please list which and why:

31. Are you taking any vitamins or supplements?

r Yes r No

32. If yes, please list which and why:

THOUGHTS: Emotional Stresses & Challenges

33. Please rate your STRESS for each:

	1 - None	2	3 - Moderate	4	5 - High
Home					
Work					
Life					
Money					
Health					
Family					

34. Are there other emotional stresses or challenges you'd like to tell us about?

35. Patient Name: ___________________________________

Signature: ______________________________________

Pregnancy Questionnaire

36. Previous Birth Experience:

Is this your first pregnancy?
r Yes r No

37. If not, please tell us about your first pregnancy and/or birth experience(s). (Duration, interventions, etc.)

____

38. Do you plan to follow the same as your previous delivery?

r Yes r No

39. If no, what would you like to change?

____
____
____
____

Conception and Early Pregnancy

40. When is your expected or calculated due date?

____

41. Did you have any difficulty conceiving?

r Yes r No

42. If yes, please explain:

____
____
____
____

43. Have you used any hormonal or oral contraceptive?

r Yes r No

44. If yes, which ones, and for how long?

____

45. When was your last menstrual cycle? ______________________

What was your pre-pregnancy weight? ______________________

Current weight? ______________________

46. Have you experienced morning sickness?

r Yes r No

47. If yes, please explain:

Current Health Conditions

48. What type of exercise(s) are you currently performing?

49. Please tell us about your current diet, and any dietary restrictions.

50. Have you taken any medications or supplements during your pregnancy?

r Yes r No

51. If yes, please list:

	Medication Name	Dosage	Frequency	Reason for Taking
1				
2				
3				

52. Have you had any slips, falls, or other physical traumas during the pregnancy?

r Yes r No

53. If *yes;* please explain:

54. Have you had any major emotional stressors during your pregnancy?

r Yes r No

55. If yes, please explain:

Your Birth Plan

56. Your top three goals for this pregnancy:

1.

2.

3.

57. Do you currently have any birth plan?

r Yes r No

58. If yes, please explain:

59. Are you taking any pre-natal or birthing class?

r Yes r No

60. If yes, please explain:

61. Who is your OB/GYN or midwife?

Will they be present for delivery?

r Yes r No

Who is your birth provider?

62. Do you intend to have a doula or birth coach present?

r Yes r No

63. If yes, please explain:

64. Do you wish to have a natural vaginal labor and delivery?

r Yes r No

65. If not, what concerns do you have?

Your Post-Birth Plan

66. Do you plan on breastfeeding your child?

r Yes r No

67. Is there anything else you'd like to tell us about your pregnancy or birth plan?

68. What would you like to gain from chiropractic care during your pregnancy?

Patient Review of Systems

The nervous system controls and coordinates all organs and structures of the human body.

Please check the corresponding boxes for each symptom or condition you have experienced - including both past and present.

69.

	Past	Present
Anxiety & Constant Stress		
Focus & ADHD Challenges		
Difficulty Sleeping		
Low Energy and Fatigue		
Depression and Mood Regulation Challenges		
Lightheadedness & Dizziness		
Vertigo		
Tension Headaches		
Migraines		
Stick Neck & Shoulders		
Pain, Numbness, & Tingling in Arms and Hands		
TMJ and Jaw Pain		
Vision & Hearing Issues		
Ear & Sinus Infections		
Sore Throat and Strep		
Strep & Upper Respiratory Infections		
Allergies and Autoimmune Challenges		
Chronic Inflammation		
Acid Reflux, GERO, & Indigestion		
Poor Metabolism & Weight Control		
High Blood Pressure		
Asthma		
Chronic Chest Colds & Cough		

Bronchitis & Pneumonia		
Functional Heart Conditions		
Gallbladder Pain & Issues		
Stomach Ulcers and Pain		
Blood Sugar Problems		
Skin Conditions/ Rash		
Ulcerative Colitis		
Crohn's Disease		
185		
Kidney Challenges		
Gas Pain & Bloating		
Gluten & Casein Intolerance		
Constipation		
Bladder & Urination Issues		
Cysts & Endometriosis		
Fertility Challenges		
Erectile Dysfunction		
Hemorrhoids		
Low Back Pain & Stiffness		
Sciatica & Radiating Pain		
Lumbopelvic / SI Joint Pain		
Disc Degeneration		
Leg Weakness & Cramps		
Restless Legs		
Poor Circulation & Cold Feet		
Weak Ankles & Arches		

ACKNOWLEDGEMENT & CONSENT

Patient Name: ______________________________________
Signature: ____

OGLE CHIROPRACTIC & REHAB CENTER, LLC
24610 Highway 17 Waynesville, MO 65583
573-774-4177

Consent to use PHI

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Ogle Chiropractic & Rehab Center LLC or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Please list those whom we may give your information to:

Name: ______________________________ Phone# ________________
Name: ______________________________ Phone# ________________
Name: ______________________________ Phone# ________________

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office.

I have **received** a copy of the Notice of Patient Privacy Policy. ____ Patient Initials

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your Protected Health Information.
This office may or may not agree to restrict the use or disclosure of your Protected Health Information. If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of Treatment in Open or Common Areas

Note that some of your treatment may be performed in an "open area". Private areas are available upon request to discuss your health information upon request. ______ Patient Initials

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

____ ________________
Patient or Legally Authorized Individual Signature — Date

____ ________________
Print Patient's Full Name — Time

____ ________________
Witness Signature — Date

Office Fee Schedule and Financial Policy

Service	Charges
Consultation	N/C
Initial Exam (Required)	$120
Progress Report	$40
Neurological Scan	$80
X-Rays (per set) 2 views min.	$75
Adjustment	$40
Acupuncture	$45
Spinal Decompression	$50
ART (Active Release Technique)	$30
E-Stim	$15
Cupping	$20
Intersegmental Traction (Roller) Table	$15
Ultrasound	$25
B12 Injection	$25
IMR Mat	$25
Diathermy	$15
No Call/No Show to Appt	$25

Financial Policy and Chiropractic Treatment Plans

Our responsibilities: We are committed to providing you with the best chiropractic care possible in a caring environment and have established our financial policies to achieve that goal. We will provide you the best service possible to meet your needs. We will correct any errors we have made if there is a dispute. We are available to answer any questions and will do our best to serve you in a polite and courteous manner. We will provide you a superbill at your request. We accept cash, credit/debit, and checks for payment of services rendered on each day. NOTE: There will be a returned check fee assessed if one is received.

Your responsibilities: Payment is expected at time of service unless you arrange a payment plan set up between you and the doctor. Know your insurance carriers' requirements for filing insurance claims. Every insurance carrier is different. We will verify your insurance coverage for you, however, remember your agreement with your insurance company is between you and them. Please contact the member services telephone number on the back of your card for more information. The information given by your insurance company is not a guarantee of coverage.

Cancellations: Please make any cancellations with at least 24 hours' notice or you will be billed a $25 no call/no show fee.

Collections: I fully understand that I am financially responsible for and agree to pay all charges. In consideration of the chiropractic services furnished to me, I hereby agree to pay Ogle Chiropractic and Rehab Center, LLC any balance due within sixty days from presentation of my bill. In the event of default, I promise to pay legal interest on Indebtedness together with 50% collection costs and attorney fees as may be required to effect collections.

Prices are subject to change at any time
I have read and I understand the above policy.

Patient Signature: ______________________________

CONSENT TO CHIROPRACTIC EXAMINATION AND CARE

I hereby authorize **Ogle Chiropractic and Rehab Center, LLC** and its licensed doctors and assistants, based on my complaints and the history I have provided, to undertake an examination and provide an evaluation and treatment which may include chiropractic adjustments and other tests and procedures considered therapeutically appropriate. I also with to rely on the practice doctors to make those decisions about my care, based on the facts then known, that they believe are in my best interest.

The nature and purpose of the chiropractic examination and evaluation, the chiropractic adjustments and the other procedures that may be recommended during the course of my care have been explained and described to my satisfaction.

By signing below I acknowledge my consent to be examined:

The specifics of the doctor's recommendation will be further explained during a Report of Findings following your examination and any subsequent examinations and significant changes in your diagnosis or treatment/treatment plan.

Based on current findings, practice doctors have discussed my diagnosis and treatment plan, the benefits and expected improvement with the proposed treatment and the reasonable alternatives to the proposed treatment. They have also explained the cost of my proposed care (or provided me with a current fee schedule) and to the extent practicable the costs of reasonable alternatives to the proposed treatment.

To aid the understanding of my condition and the reasons for the proposed course of care, the practice has provided me with the specific pamphlets and other literature and practice doctors have answered my questions regarding the planned treatments and course of care that I will receive. Practice doctors have also explained that my diagnosis and treatments may change during the course of care and that they will advise me of material changes in my diagnosis and treatment options and answer any additional questions that I may have at anytime.

I have also been advised that although the incidence of complications associated with chiropractic services is very low, anyone undergoing adjusting or manipulative procedures should know of rare possible hazards and complications which may be encountered or result during the course of care. These include, but are not limited to, fractures, disk injuries, strokes, dislocations, sprains, and those which relate to physical aberrations unknown or reasonably undetectable by the doctor.

I understand and accept that:

1. I have the right to withdraw from or discontinue treatment at any time and that the Practice doctors will advise me of any material risks in this regard.
2. That neither the practice of chiropractic nor medicine is an exact science and that my care may involve the making of judgments based upon the facts known to the doctor during the course of my care.
3. That it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications or an undesirable result does not necessarily indicate an error in judgment or treatment.
4. The Practice does not guarantee as to results with respect any course of care or treatment.
5. My care and treatment will not be observed or recorded for any non-therapeutic purpose without my consent.

I have read this Consent (or have had it read to me) and have also had an opportunity to ask questions about the Consent and understand to my satisfaction the care and treatment I may receive. My signature below acknowledges my consent to the examination, evaluation and purposed course of care and treatments by the Practice.

Patient's Printed Name ______________________ Patient's Signature _____________

Patient counseled by: ____

Signature of doctor

OGLE CHIROPRACTIC PHOTO RELEASE

I, on behalf of myself and/or my minor children, hereby grant Ogle Chiropractic, LLC, (OC) and its officers, chiropractors, owners and employees the right to take photographs of myself and my minor child(ren), while on the premises of OC or while attending any offsite event hosted or otherwise sponsored by OC or any of OC's affiliate businesses. I further give permission for the use of such photographs in advertising, business, web-hosted, social media account, or educational materials promulgated, created, designed, purchased or otherwise used by OC for purposes of promoting OC. I hereby waive any applicable right of privacy that I may assert on behalf of myself or my minor child(ren), and further agree that such photos may be used for any additional lawful purposes related to promoting OC and its affiliates as well as chiropractic treatment in general. To the extent that such disclosures show a doctor/patient relationship, I hereby waive such privilege on behalf of myself and my minor child(ren) for the limit purposes enumerated herein specifically related to photographic material.

I have fully read and understand the implications of this wavier and release and hereby affix my signature in acknowledgment of my agreement with such terms. By affixing my signature below, I am also confirming that I am at least 18 years of age, or, if signing on behalf of a minor child, that I am at least 18 years of age.

I am at least 18 years of age and have read and

understand the above:

Patient Name: ______________________________________

If under 18 years of age the legal guardian or parent has read and

understands the above:

Parent/Guardian Name:

____

____________________________________ ____________________

Patient Signature **Date**

OG LE CH I ROPRACTIC

INSURANCE DISCLOSURE

Our practice is committed to providing the best care possible and because of that, we would like to inform you our office does not accept any insurance. This decision has been made to ensure we can continue to deliver the highest quality care without the limitations often imposed by insurance companies.

We are unable to accept any new patients who are covered under Medicare. If a patient chooses not to disclose or is dishonest about having Medicare coverage, any financial responsibilities or issues that arise will fall solely on the patient.

All services will be provided on a self pay basis, and payment will be due at the time of your appointment.

Patient Signature: ___________________________________

Date:____