PREGNANCY QUESTIONNAIRE

Patient Name: _____ **Date:** _____

PREVIOUS BIRTH EXPERIENCE

Is this your first pregnancy? ◯ Yes ◯ No

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

_____

Do you plan to follow the same plan as your previous delivery? ◯ Yes ◯ No

If no, what would you like to change?

_____

CONCEPTION & EARLY PREGNANCY

When is your expected or calculated due date? _____

Did you have any difficulty conceiving? ◯ Yes ◯ No

If yes, please explain: _____

Have you ever used any form of hormonal contraceptives? ◯ Yes ◯ No

If yes, which ones, and for how long? _____

When was your last menstrual cycle? _____

What was your pre-pregnancy weight? _____ Current weight? _____

Have you experienced any morning sickness? ◯ Yes ◯ No

If yes, please explain: _____

CURRENT HEALTH CONDITIONS

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

_____

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

_____

Have you taken any medications or supplements during your pregnancy? ◯ Yes ◯ No

If yes, please explain: _____

Have you had any slips, falls, or other physical traumas during the pregnancy? ◯ Yes ◯ No

If yes, please explain: _____

Have you had any major emotional stressors during your pregnancy? ◯ Yes ◯ No

If yes, please explain: _____

PREGNANCY QUESTIONNAIRE

Patient: _____

Date: _____

YOUR BIRTH PLAN

Your top three goals for this pregnancy:

1. _____
2. _____
3. _____

Do you currently have a birth plan? ◯ Yes ◯ No

If yes, please explain: _____

Are you taking any pre-natal or birthing classes? ◯ Yes ◯ No

If yes, please explain: _____

Who is your OB/GYN or midwife? _____

Do you intend to have a doula or birth coach present? ◯ Yes ◯ No

If yes, please explain: _____

Do you wish to have a natural, vaginal labor and delivery? ◯ Yes ◯ No

If not, what concerns do you have? _____

YOUR POST-BIRTH PLAN

Do you plan on breastfeeding your child? ◯ Yes ◯ No

What do you intend to do regarding vaccines? _____

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

_____

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

_____

Are there any burning questions you want to be sure to ask today?

_____

p: (720)390-5757 w: sozocastlerock.com e: info@sozocastlerock.com

PATIENT QUESTIONNAIRE & HISTORY

Patient: _____

Date: _____

PATIENT INFORMATION

First Name: _____ Last Name: _____

Birth Date: _____ Height: _____ Weight: _____ Occupation: _____

Address: _____

City: _____ State: _____ ZIP: _____

Email: _____ Cell Phone: _____

Names & Ages of Children: _____

Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Widowed ◯ Other

Emergency Contact: _____ Relationship: _____

Cell Phone: _____ Work Phone: _____

How did you hear about us? _____

Are you also receiving care from any other health care provider? ◯ Yes ◯ No

If yes, please name them and their specialty: _____

Date and reason for last doctor visit: _____

Please note any significant family medical history: _____

CURRENT HEALTH CONDITIONS

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

_____

Have you received care for this problem before? ◯ Yes ◯ No

If yes, please explain: _____

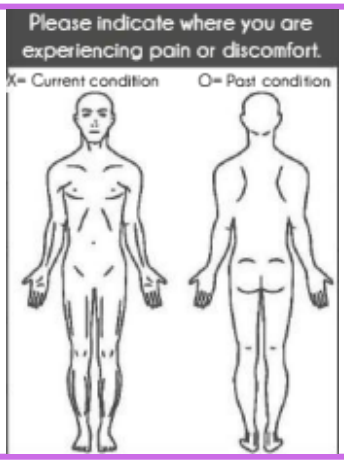
When did the condition(s) begin? _____

How did the problem start? ◯ Suddenly ◯ Gradually ◯ Post-Injury

Is this condition: ◯ Getting Worse ◯ Improving ◯ Intermittent ◯ Constant ◯ Unsure

What makes the problem worse? _____

What makes the problem better? _____



YOUR HEALTH GOALS

Your top three health goals:

1. _____
2. _____
3. _____

CHIROPRACTIC HISTORY

What would you like to gain from chiropractic care?

◯ Resolve existing condition(s) ◯ Overall wellness ◯ Both

Have you ever visited a chiropractor? ◯ Yes ◯ No If yes, what is their name? _____

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

_____

TRAUMAS: PHYSICAL INJURY HISTORY

Have you had any significant falls, surgeries, or other injuries as an adult? ◯ Yes ◯ No

If yes, please explain: _____

Notable childhood injuries? ◯ Yes ◯ No If yes, please explain: _____

Youth or college sports? ◯ Yes ◯ No If yes, list major injuries: _____

Any auto accidents? ◯ Yes ◯ No If yes, please explain: _____

Exercise frequency? ◯ None ◯ 1-2x per week ◯ 3-5x per week ◯ Daily

What type of exercise? _____

How do you normally sleep? ◯ Back ◯ Side ◯ Stomach

Do you wake up: ◯ Refreshed & ready ◯ Stiff & tired

Do you commute to work? ◯ Yes ◯ No If yes, how many minutes per day? _____

List any problems with flexibility (ex: putting on shoes/socks, etc): _____

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

TOXINS: CHEMICAL & ENVIRONMENTAL EXPOSURE

Please rate your CONSUMPTION for each:

	None		Moderate		High		None		Moderate		High
Alcohol	①	②	③	④	⑤	**Procesed Food**	①	②	③	④	⑤
Water	①	②	③	④	⑤	**Artificial Sweeteners**	①	②	③	④	⑤
Sugar	①	②	③	④	⑤	**Sugary Drinks**	①	②	③	④	⑤
Dairy	①	②	③	④	⑤	**Cigarettes**	①	②	③	④	⑤
Gluten	①	②	③	④	⑤	**Recreational Drugs**	①	②	③	④	⑤

List any drugs/medications/vitamins/herbs/other that you are taking and why:

_____

THOUGHTS: EMOTIONAL STRESSES & CHALLENGES

Please rate your STRESS for each:

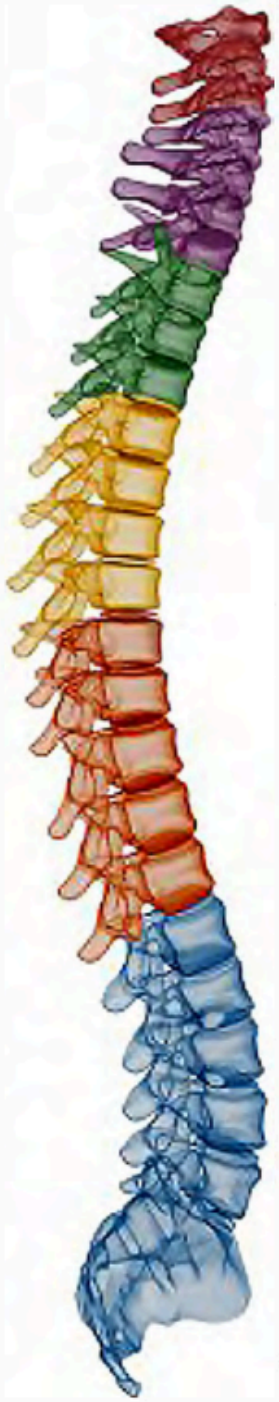
	None		Moderate		High		None		Moderate		High
Home	①	②	③	④	⑤	**Money**	①	②	③	④	⑤
Work	①	②	③	④	⑤	**Health**	①	②	③	④	⑤
Life	①	②	③	④	⑤	**Family**	①	②	③	④	⑤

PATIENT REVIEW OF SYSTEMS

Patient: _____

Date: _____

The nervous system controls and coordinates all organs & structures of the human body. Please review the following symptoms and check if you have had any past or present symptoms.



REGIONS	FUNCTIONS	SYMPTOMS	
		PAST / PRESENT	PAST / PRESENT
Cervical	• Autonomic Nervous System • ENT System • Vision, Balance, & Coordination • Speech • Immune System • Digestive System • Nerve Supply to Shoulders, Arms & Hands • Metabolism	☐☐ Colic & Excessive Crying ☐☐ Ear & Sinus Infections ☐☐ Allergies & Congestion ☐☐ Immune Deficiency ☐☐ Headaches & Migraines ☐☐ Vertigo & Dizziness ☐☐ Sore Throat & Strep ☐☐ Swollen Tonsils & Adenoids ☐☐ Vision & Hearing Issues ☐☐ Low Energy & Fatigue ☐☐ Difficulty Sleeping ☐☐ Pain, Numbness, & Tingling in Arms to Hands	☐☐ Epilepsy & Seizures ☐☐ Sensory & Spectrum ☐☐ ADD / ADHD ☐☐ Focus & Memory Issues ☐☐ Anxiety & Stress ☐☐ Balance & Coordination ☐☐ Speech Issues ☐☐ TMJ / Jaw Pain ☐☐ Stiff Neck & Shoulders ☐☐ Depression ☐☐ High Blood Pressure ☐☐ Poor Metabolism & Weight Control
Upper Thoracic	• Upper G.I. • Respiratory System • Cardiac Function	☐☐ Reflux / GERD ☐☐ Chronic Colds & Cough ☐☐ Asthma	☐☐ Bronchitis & Pneumonia ☐☐ Functional Heart Conditions
Mid Thoracic	• Major Digestive Center • Detox & Immunity	☐☐ Gallbladder Pain / Issues ☐☐ Jaundice ☐☐ Fever	☐☐ Indigestion & Heartburn ☐☐ Stomach Pains & Ulcers ☐☐ Blood Sugar Problems
Low Thoracic	• Stress & Response • Filtration & Elimination • Gut & Digestion • Hormonal Control	☐☐ Behavior Issues ☐☐ Hyperactivity ☐☐ Chronic Fatigue ☐☐ Chronic Stress	☐☐ Allergies & Eczema ☐☐ Skin Conditions / Rash ☐☐ Kidney Problems ☐☐ Gas Pain & Bloating
Lumbar, Sacrum, & Pelvis	• Lower G.I (Absorption & Motility) • Gut Immune System • Major Hormonal Control	☐☐ Constipation ☐☐ Chrohn's, Collitis, & IBS ☐☐ Diarrhea ☐☐ Bed Wetting ☐☐ Bladder & Urination Issues ☐☐ Cramps & Menstrual Issues ☐☐ Cysts & Endometriosis ☐☐ Infertility ☐☐ Impotency ☐☐ Hemorrhoids	☐☐ Sciatica & Radiating Pain ☐☐ Lumbopelvic / SI Joint Pain ☐☐ Hamstring Tightness ☐☐ Disc Degeneration ☐☐ Leg Weakness & Cramps ☐☐ Knee, Ankle, & Foot Pain ☐☐ Weak Ankles & Arches ☐☐ Lower Back Pain ☐☐ Gluten & Casein Intolerance ☐☐ Poor Circulation & Cold Feet

Patient Name: _____ Patient Signature: _____

POLICIES AND FEE ACKNOWLEDGEMENT

Patient: _____

Date: _____

RELEASE OF AUTHORIZATION / ASSIGNMENT OF BENEFITS

I authorize and request payment of insurance benefits directly to Dr. Joseph Schmitt DC. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that I have certain rights of privacy regarding my protected health information, under the health insurance portability and accountability act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct a normal healthcare operations, such as quality assessments and physicians certifications.

I acknowledge I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree with my requested restrictions, but if you agree you are bound to abide by such restrictions.

FEE ACKNOWLEDGEMENT

There is no guarantee of insurance reimbursement for services provided by Sozo Integrative Health. Sozo Integrative Health is an out of network provider and is only able to provide Superbills upon request. You will be responsible for payment for services at time of service.

• Chiropractic Adjustments	$75
• Spinal Decompression	$120
• Softwave Treatment	$199
• X-Ray Series	$150
• Thermography Scan	$75

We accept the following forms of payment: American Express, Master Card, Visa, Discover, Checks, Cash*

Patient Name: _____ Patient Signature: _____

TERMS OF ACCEPTANCE

Patient: _____

Date: _____

In order to provide for the most effective healing environment, most effective application of chiropractic
procedures, and the strongest possible doctor patient relationship, it is our wish to provide each patient
with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.
To that end, we ask that you would acknowledge the following points regarding chiropractic care in the services that are offered through this clinic:

1. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs.
2. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of the spinal subluxation(s). Subluxations are deviations from the normal spinal structures and configurations that interfere with normal nerve processes.
3. The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region or regions of the spine with a specific intent of positioning misaligned spinal segments. This is a safe, effective procedure applied over 1 million times each day by Doctors of Chiropractic in the United States, alone.
4. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indicators of need.
5. Chiropractic does not seek to replace or compete with your medical, dental, or other types of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
6. Your compliance with care recommendations, home and self-care, etc., is essential to maximum healing in optimal health through chiropractic.
7. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration, or cost. We work to maintain as a supporting, open environment.

By my signature below, I have read and fully understand the above statements. All my questions regarding the doctors objectives pertaining to my care in this office have been answered to my satisfaction. I, therefore, accept chiropractic care on this basis.

Patient Name: _____ Patient Signature: _____

INFORMED CONSENT FOR CHIROPRACTIC CARE

Patient: _____

Date: _____

Chiropractic care, like all forms of healthcare, while offering considerable benefits may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases, injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include: sprain/strain injuries, irritation of a disc condition, and rarely, fractures. Prior to receiving chiropractic care in this chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific conditions, your overall health, and in particular your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examination or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with care recommendations prior to beginning care.

I understand and accept there are risks associated with chiropractic care. I give consent to the examination and the chiropractic care the doctor deems necessary, including spinal adjustments, as reported following my assessment.

Patient Name: _____ Patient Signature: _____

If a patient is a minor/child, parent or guardian must sign below.

Signature of Patient/Guardian: _____

Relationship to Minor: _____

Witness Signature (office staff): _____