

Patient Introduction Card

Today's Date _____

Account # _____

Full Legal Name _____ Prefer To Be Called _____

Home Address _____ Occupation _____

City _____ State _____ Zip _____ Employer _____

Home Phone _____

Name of Insurance Co _____

Cell Phone _____

Policy Holder Name _____

Work Phone _____

Policy Holder Date of Birth _____

Email _____

Primary Care Doctor _____

Date of Birth _____ Age _____

Previous Chiropractic Care? YES NO

Married Single Other _____

Major Complaint Today _____

Social Security # _____

Preferred method of contact for appointment reminders Text Email Either is fine

Who (or what source) referred you to our office? _____

It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged

Prenatal Health Questionnaire

Patient Name: _____ Date: _____

Congratulations on your current pregnancy! Please help us help you by providing us with the following information:

CURRENT PREGNANCY:

Position of baby (circle): Unknown Breech Posterior Transverse Vertex

weeks pregnant: _____ Due Date: _____

Gender of baby (circle): M F Baby #: _____

Birth plan (circle): Home birth Birthing Center Hospital

Your delivery plan (circle all that apply): OB/GYN Midwife Doula Other: _____

PREVIOUS PREGNANCIES:

of previous pregnancies: _____ # of previous deliveries: _____

Delivery complications (circle): None Forceps Vacuum extraction Cesarean

Please explain any delivery complications: _____

If there was a cesarean, what was the reason?: _____

Please check any of the following that you would like more information on:

- | | | |
|---|---|--|
| <input type="checkbox"/> Chiropractic care for infants & toddlers | <input type="checkbox"/> Baby wearing | <input type="checkbox"/> Lactation consultant |
| <input type="checkbox"/> Prenatal yoga | <input type="checkbox"/> Birthing classes | <input type="checkbox"/> Meal planning |
| <input type="checkbox"/> Prenatal massage | <input type="checkbox"/> Doula recommendation | <input type="checkbox"/> Postpartum emotional wellness |
| <input type="checkbox"/> Prenatal acupuncture | <input type="checkbox"/> Midwife recommendation | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Pregnancy support belts | <input type="checkbox"/> OB/GYN recommendation | |

Webster Consent

Please initial each statement

_____ I acknowledge that the Webster technique is a specific Chiropractic analysis and diversified adjustment. The goal of the adjustment is to establish balance to the structure (joints, muscles, and ligaments) of the mother's pelvis, improving neuro-biomechanical function and allowing the uterus to enlarge symmetrically with the growing baby.

_____ I acknowledge that due to the cumulative effect of stress and trauma to the spine, pelvis, and sacrum over a lifetime, the diameter of the pelvic opening may be compromised which can lead to _____ intrauterine constraint. According to Williams Obstetrics text, any diminished capacity of the pelvis or displacement of the sacrum can lead to dystocia (difficulty) during labor. The correction of these misalignments via the Webster Technique, can have a positive effect on (A) the mother's comfort level throughout _____ pregnancy, (B) the ability of the baby to get into optimal positioning for birth, and (C) the causes of difficult labor.

_____ I acknowledge that this is not a breech turning technique or External Cephalic Version procedure and that the Doctor will in no way be manually manipulating the baby's positioning. Often mothers report feeling an increase in the baby's movement later on in the day following an adjustment, which is considered positive because it indicates that the baby now has more room to do so.

_____ I understand that in rare cases it is possible to have some minor soreness after my first few adjustments, especially if I have never been adjusted before. My Chiropractor will give me specific at home instruction to help avoid this.

_____ I acknowledge that Chiropractic care throughout pregnancy allows for healthier function of the mother and baby. The Webster Technique is tailored to pregnant moms to create balance in the mother's pelvic bones, sacrum, and surrounding muscles and ligaments, therefore reducing the possibility of intrauterine constraint. This offers the baby to get into the best possible positioning for birth which can lead to a safer easier delivery. Chiropractic care during pregnancy is a safe, effective way to support the natural process of birthing.

_____ I acknowledge that all Chiropractic care provided to me in the office will be performed by a licensed, experienced, certified Webster Technique Doctor of Chiropractic.

_____ I authorize Tagliarini Chiropractic to provide my OBGYN or Midwife medical records as needed.

Patient Name (printed)

Signature

Date: _____

Patient Health Questionnaire

Patient Name _____ Date _____

1. Describe your current symptoms (*Begin with what bothers you the most*): _____

2. Do your symptoms radiate (travel)? Yes No If yes, to what part of your body? _____

3. How long have your symptoms been present?
This episode: _____ First episode EVER: _____

4. When is it most noticeable? Upon Waking During the day Afternoon Evening While Trying to sleep

5. What activities make your symptoms worse? Ice Rest Sitting Medication
 Heat Activity Standing _____

6. What activities make your symptoms better? Ice Rest Sitting Medication
 Heat Activity Standing _____

7. What describes the nature of your symptoms?

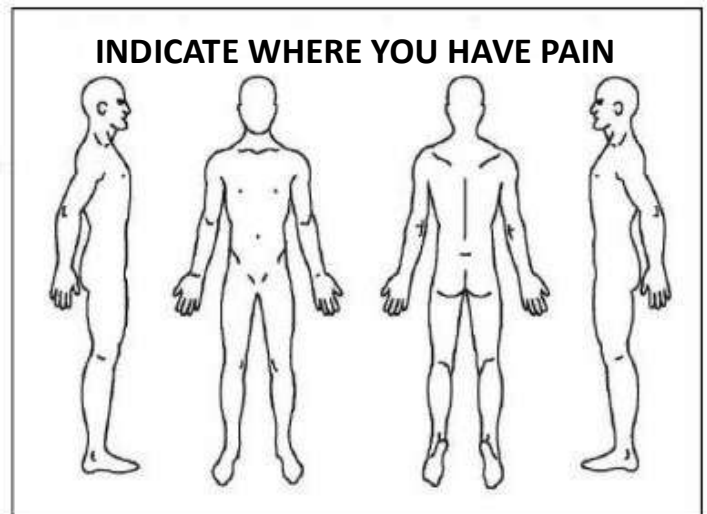
- | | |
|--|--|
| <input type="checkbox"/> Dull and aching | <input type="checkbox"/> Burning |
| <input type="checkbox"/> Sharp with movement | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Numb | <input type="checkbox"/> Tight / Stiff |
| <input type="checkbox"/> Shooting | <input type="checkbox"/> Sore |

8. How often are your symptoms present?

- | | |
|--|---|
| <input type="checkbox"/> Occasional (0-25%) | <input type="checkbox"/> Frequent (50-75%) |
| <input type="checkbox"/> Intermittent (25-50%) | <input type="checkbox"/> Constant (75-100%) |

9. Who else have you seen for your current symptoms?

- | | | |
|---|---|--------------------------------------|
| <input type="checkbox"/> No One | <input type="checkbox"/> Orthopedic Doctor | <input type="checkbox"/> OTHER _____ |
| <input type="checkbox"/> This Office | <input type="checkbox"/> Neurologist | |
| <input type="checkbox"/> Other Chiropractor | <input type="checkbox"/> Physical Therapist | |
| <input type="checkbox"/> Medical Doctor / PCP | <input type="checkbox"/> Massage Therapist | |
| <input type="checkbox"/> OBGYN / Midwife | <input type="checkbox"/> Acupuncturist | |
| | | |



10. What tests have you had for your symptoms? None MRI date: _____
 X-rays date: _____ CT Scan date: _____

11. What describes the severity of your symptoms? **None** 1 2 3 4 5 6 7 8 9 10 **Severe**

12. What other forms of care have you tried for your current complaint?

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Nothing | <input type="checkbox"/> Advil / Tylenol / Aleve (CIRCLE) | <input type="checkbox"/> Chiropractic Care | <input type="checkbox"/> Yoga |
| <input type="checkbox"/> Prescription Pain Meds | <input type="checkbox"/> Injections | <input type="checkbox"/> Acupuncture | <input type="checkbox"/> CBD |
| <input type="checkbox"/> Muscle Relaxer | <input type="checkbox"/> Massage Therapy | <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> New Mattress / Pillow (CIRCLE) |
| <input type="checkbox"/> Ice / Heat (CIRCLE) | <input type="checkbox"/> Foam roller | <input type="checkbox"/> Stretching | <input type="checkbox"/> _____ |

13. What do you feel caused your symptoms? Fall Lifting Work Posture
 Car Accident Don't Know _____

14. What activities are affected by your symptoms?

- | | | | | |
|---|-----------------------------------|---|-------------------------------------|--------------------------------|
| <input type="checkbox"/> Work/School (CIRCLE) | <input type="checkbox"/> Exercise | <input type="checkbox"/> Driving/Riding in Car (CIRCLE) | <input type="checkbox"/> House Work | <input type="checkbox"/> Mood |
| <input type="checkbox"/> Getting dressed | <input type="checkbox"/> Running | <input type="checkbox"/> Caring for Children | <input type="checkbox"/> Yard Work | <input type="checkbox"/> Focus |
| <input type="checkbox"/> Sleeping | <input type="checkbox"/> Walking | <input type="checkbox"/> Going up / down stairs | <input type="checkbox"/> Bathing | <input type="checkbox"/> _____ |

For each of the conditions listed below, place a check in the PAST column if you have had the condition in the past.

Place a check in the PRESENT column if you currently have the conditions listed.

16. 17.

PAST	PRESENT		PAST	PRESENT		PAST	PRESENT	
<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/>	Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Urination
<input type="checkbox"/>	<input type="checkbox"/>	Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Hypo-Thyroid
<input type="checkbox"/>	<input type="checkbox"/>	Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	Hyper-Thyroid
<input type="checkbox"/>	<input type="checkbox"/>	Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Smoking/Tobacco Use
<input type="checkbox"/>	<input type="checkbox"/>	Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Drug/Opioid Dependence
<input type="checkbox"/>	<input type="checkbox"/>	Elbow Pain	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol Dependence
<input type="checkbox"/>	<input type="checkbox"/>	Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Food Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Hand Pain	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Carpal Tunnel	<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety
<input type="checkbox"/>	<input type="checkbox"/>	Hip Pain	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Illness
<input type="checkbox"/>	<input type="checkbox"/>	Knee Pain	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Ankle Pain	<input type="checkbox"/>	<input type="checkbox"/>	Reflux/Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	Dermatitis
<input type="checkbox"/>	<input type="checkbox"/>	Foot Pain	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Weight Gain	<input type="checkbox"/>	<input type="checkbox"/>	Eczema
<input type="checkbox"/>	<input type="checkbox"/>	Sciatica	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	Poison Ivy/Oak
<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain/TMJ	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Appetite	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Constipation			
<input type="checkbox"/>	<input type="checkbox"/>	Joint Swelling/Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain			
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer			
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis			
<input type="checkbox"/>	<input type="checkbox"/>	Lyme Disease	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Hot Flashes
<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis/Osteopenia	<input type="checkbox"/>	<input type="checkbox"/>	Gall Bladder Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Hormone Replacement
<input type="checkbox"/>	<input type="checkbox"/>	General Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Birth Control Pills
<input type="checkbox"/>	<input type="checkbox"/>	Ringing in Ears	<input type="checkbox"/>	<input type="checkbox"/>	Tumor	<input type="checkbox"/>	<input type="checkbox"/>	Painful Periods/Cramps
<input type="checkbox"/>	<input type="checkbox"/>	Visual Disturbances	<input type="checkbox"/>	<input type="checkbox"/>	Asthma			
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Sinusitis	YES	NO	Are You Pregnant?
<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Seasonal Allergies			

Females Only

18. Primary Care Physician _____ 18b. Date of Last Medical Physical _____

19. Indicate if an immediate family member has had any of the following:

Rheumatoid Arthritis Heart Problems Diabetes Cancer Lupus Other: _____

20. List all prescription and over-the-counter medications, nutritional/herbal supplements, essential oils, or CBD you are taking:

21. List all the surgical procedures you have had AND times you have been hospitalized (INCLUDING GIVING BIRTH):

22. ANY & ALL LIFETIME TRAUMA HISTORY to head, neck, or back, EVEN IF YOU DID NOT HAVE SYMPTOMS OR TREATMENT:

Concussions: _____

Sports Injuries: _____

Auto Accidents: _____

Other Physical Traumas: _____

PATIENT SIGNATURE: _____ Date: _____