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 Questionanaire

Patient Name: _____ Date: _____

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

CURRENT PREGNANCY:

You are here for (circle all that apply): Wellness Discomfort Baby position

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

weeks pregnant: _____ Due Date: _____

Gender of baby (circle): M F Don't know yet Not finding out Baby #: _____

Birth plan (please specify where): Home birth Birthing Center:_____ Hospital_____

Your delivery plan (please specify who): OB/GYN:_____ Midwife:_____ Doula:_____

May we have your permission to contact your pre-natal provider regarding your care? Y N

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?: _____

_____

_____

Interested in more information on the following:

- ☐ Infant & toddler Chiropractic
- ☐ Prenatal yoga
- ☐ Prenatal massage
- ☐ Prenatal acupuncture
- ☐ Pregnancy support belts
- ☐ Baby wearing
- ☐ Birthing classes
- ☐ Doula recommendation
- ☐ Midwife recommendation
- ☐ OB/GYN recommendation
- ☐ Pregnancy photography
- ☐ Lactation consultant
- ☐ Breast pump recommendation
- ☐ Meal planning
- ☐ Postpartum emotional wellness

Webster Consent

Please initial each statement

_____I acknowledge that the Webster technique it 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.

Patient Health Questionnaire

Patient Name_____ **Date**_____

1. What are your current symptoms (List the worst one first):

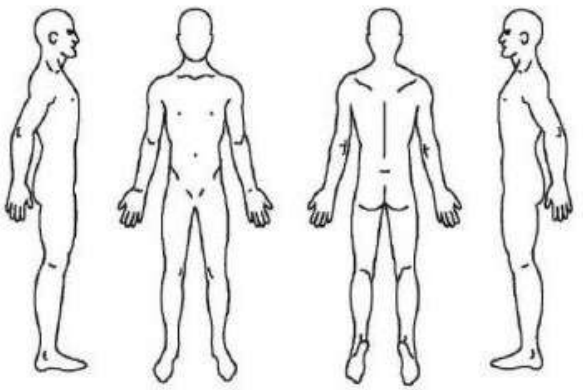
_____

_____

_____

_____

INDICATE WHERE YOU HAVE PAIN



2. How long have you had your main symptom?

This episode: _____

First episode EVER: _____

3. How often are your symptoms present?
□ Occasional (0-25%) □ Frequent (50-75%)
□ Intermittent (25-50%) □ Constant (75-100%)

4. What do you feel caused your symptoms?
□ Car Accident □ Fall □ Sports Injury □ Lifting
□ Work □ Posture □ Other_____

5 What have you tried for your current complaint?
□ Nothing □ Advil / Tylenol / Aleve (CIRCLE) □ Chiropractic Care □ Yoga
□ Prescription Pain Meds □ Injections □ Acupuncture □ CBD
□ Muscle Relaxer □ Massage Therapy □ Physical Therapy □ New Mattress / Pillow (CIRCLE)
□ Ice / Heat (CIRCLE) □ Foam roller □ Stretching □ _____

6. Who else have you seen for your current symptoms?
□ No One □ Medical Doctor / PCP □ Neurologist □ Acupuncturist
□ This Office □ OBGYN / Midwife □ Physical Therapist □ OTHER _____
□ Other Chiropractor □ Orthopedic Doctor □ Massage Therapist

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

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

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

10. What describes the nature of your symptoms?
□ Dull □ Aching □ Numb □ Burning □ Tight / Stiff
□ Sharp with movement □ Shooting □ Tingling □ Sore

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

12. What is the severity of your symptoms (CIRCLE the range)? 0 1 2 3 4 5 6 7 8 9 10

13.What activities are affected by your symptoms?
□ Work/School (CIRCLE) □ Exercise □ Driving/Riding in Car (CIRCLE) □ House Work □ Mood
□ Getting dressed □ Running □ Caring for Children □ Yard Work □ Focus
□ Sleeping □ Walking □ Going up / down stairs □ Bathing □ _____

14. Have your symptoms been getting... □ Better □ Worse □ Staying the same

Please check any condition below that you had in the past or have currently...

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

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 (INLCUDING GIVING BIRTH):

_____

_____

22. ANY & ALL LIFETIME TRAUMA HISTORY, EVEN IF YOU DID NOT HAVE SYMPTOMS OR TREATMENT:

Auto Accidents:_____

Falls: _____

Sports Injuries:_____

Concussions:_____

Other Physical Traumas: _____

23. Age of Mattress:_____ years Sleep Position: □ back □ side □ stomach # of pillows under your head?_____

PATIENT SIGNATURE:_____ **Date:**_____