

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Demographics**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Birth Date: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_ Age: \_\_\_\_\_\_\_ **□** Male □ Female

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_\_

E-mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status:  Single  Married Do you have Insurance: **□**Yes **□** No

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Number of children and Ages:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name & Number of Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight \_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Whom may we thank for referring you to this office \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_?*

**Social History:** (Circle all that apply to you)

Caffeine use: ⁫ occasional ⁫ often ⁫ never

Drink Alcohol: ⁫ occasional ⁫ often ⁫ never

Exercise: ⁫ occasional ⁫ often ⁫ never

Drink Water: ⁫ <64 oz/day ⁫>64 oz/day ⁫ never

Cigarettes: ⁫<1 pack/day ⁫ >1 pack/day ⁫ never

Sleep: ⁫<8 hours/night ⁫ ≥8 hours/night Insomnia

**Medical Conditions:** (Circle all that apply to you)

Arthritis Cancer **⁫** Diabetes **⁫** Heart Disease

Hypertension **⁫** Psychiatric Illness **⁫** Skin Disorder **⁫** Stroke

Fibromyalgia Asthma Osteoporosis

**Surgeries:** (Circle all that apply to you)

Appendectomy **⁫** cardiovascular procedure **⁫**Cervical spine Hysterectomy

Joint Replacement **⁫** Prostate **⁫** Lumbar spine **⁫** GallBladder

Brain **⁫** Shoulder **⁫** Thoracic spine **⁫** Knee

Carpal Tunnel **⁫** Gastro-intestinal **⁫** Uro-genital **⁫** HerniaBreast Augmentation Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list all current medications/vitamins:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PATIE

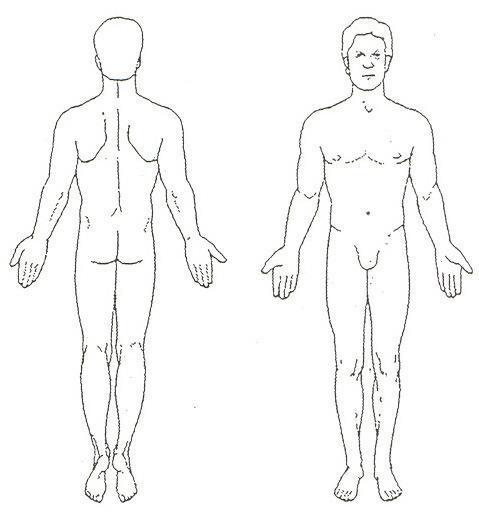
NT CONDIT

**Current Complains**

* What is the reason for your visit today?□ Headache □ Neck Pain □ Mid-Back Pain □ Low Back Pain □Other\_\_\_\_\_\_
* What caused this complaint(s)?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* When did this complaint begin? \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ Is it getting worse? □ Yes □ No □ Constant □ Comes and goes
* What does your complaint (s) feel like? Circle all that apply: Sharp / Dull / Sore / Stiff / Tight / Aching / Spasms / Throbbing / Stabbing / Shooting / Burning / Cramping / Nagging / Tingling / Numbness / Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



←Please Circle or make an “X” on the body diagram to the left where you have pain or other symptoms.

Area for doctor’s notes:

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| On the scale below, please circle the severity of your main complaint right now: | | | | | | | | | | | | | |  |
| No Pain | |  |  |  |  | Moderate Pain | | |  |  | Worst Possible Pain | | | |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 0 |  | 1 | 2 | 3 | 4 |  | 5 |  | 6 | 7 | 8 | 9 |  | 10 |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

* What area(s) does the pain radiate, shoot, or travel to? (if applicable)?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* What aggravates this complaint? Circle all that apply: Sitting / Standing / Walking / Getting up from seat / Walking stairs / Inactivity / Sleeping / Physical Activity / Exercise / Movement / Bending forward / Bending backward / Twisting / Reaching /Lifting / Desk work / Sneezing / Coughing / Everything / Unknown / Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* What relieves this complaint? Circle all that apply: Sitting / Standing / Walking / Resting / Exercise / Movement / Stretching/ Massage / Chiropractic / Heat / Ice / Laying down / Medication / Nothing / Unknown / Other:\_\_\_\_\_\_\_\_\_\_\_\_\_
* How often do you experience your symptoms? □ 25% of the day □ 50% of the day □ 75% of the day □100% of the day Timing of complaint: Check appropriate box: □ Morning □ As day progresses □ Afternoon □ Evening □ While sleeping□ During activities □ After activities □ Symptoms are constant and do not change □ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Have you seen any other doctor for this complaint? □ Yes □ No If “Yes”, please provide the following information:

Doctor’s name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date consulted:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Diagnosis\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Is this condition interfering with your: (Circle all that apply) Sleep / Getting in or out of bed or chair / Personal care / Travel /Work / Recreation / Lifting / Walking / Standing / Daily Routine / Social Activities / Exercise / Other:\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Pregnancy**

Due Date/Week I am in my: week of pregnancy.

Pre-pregnancy weight

Current Weight

Height

Childbirth preparation: Bradley

LaMaze

Other

Childbirth caregiver(s): OB/GYN Doula Midwife

Last visit to caregiver Care-giver name & phone #

I plan on giving birth at: Hospital

Home

Birth Center

Name of Hospital or Birth Center

Any traumas during this pregnancy? If yes, please describe:

Any hospitalizations during this pregnancy? If yes, please describe:

Any medications during this pregnancy, including over the counter medication? Please describe:

Any fertility treatment? If yes, please describe:

Any other information about your pregnancy?

Did you have chiropractic care during your previous pregnancies? Y N

**After 32nd Week of Pregnancy**

Position of baby: Head down Posterior Breech or malpositioned

Confirmed by: Palpation by:

Ultrasound by

Date:

Date:

How long do you believe baby has been in this position?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Review of Systems**

(Check box if you have had trouble with any of the following)

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Past | Present | No |  | Past | Present | No |
| Headache |  |  |  | Depression |  |  |  |
| Dizziness |  |  |  | Anxiety |  |  |  |
| Prostate Problems |  |  |  | Stress |  |  |  |
| Heartburn |  |  |  | Arthritis |  |  |  |
| Frequent Cold/Flu |  |  |  | Joint Stiffness |  |  |  |
| Loss of Balance |  |  |  | Gall Bladder Problems |  |  |  |
| Jaw Pain/TMJ |  |  |  | Constipation  /Diarrhea |  |  |  |
| High Blood Pressure |  |  |  | Colon issue |  |  |  |
| Difficulty Sleeping |  |  |  | PMS |  |  |  |
| Ringing in Ears |  |  |  | Sinus |  |  |  |
| Bed Wetting |  |  |  | Foot or Knee Problems |  |  |  |
| Menstrul Problems |  |  |  |  |  |  |  |
| Low Blood Pressure |  |  |  | Digestive  problems |  |  |  |
| Chest Pain |  |  |  | Ulcers |  |  |  |
| Menopause Problems |  |  |  | Allergies |  |  |  |
| Asthma |  |  |  | Kidney Disease |  |  |  |

**ACTIVITIES OF LIFE**

ACTIVITIES: EFFECT:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Carrying/Lifting Groceries | □ No Effect | □ Painful (can do) | □ Painful (limits) | □ Unable to Perform |
| Sit to Stand | □ No Effect | □ Painful (can do) | □ Painful (limits) | □ Unable to Perform |
| Climbing Stairs | □ No Effect | □ Painful (can do) | □ Painful (limits) | □ Unable to Perform |
| Pet Care | □ No Effect | □ Painful (can do) | □ Painful (limits) | □ Unable to Perform |
| Driving | □ No Effect | □ Painful (can do) | □ Painful (limits) | □ Unable to Perform |
| Extended Computer Use | □ No Effect | □ Painful (can do) | □ Painful (limits) | □ Unable to Perform |
| Household Chores | □ No Effect | □ Painful (can do) | □ Painful (limits) | □ Unable to Perform |
| Lifting Children | □ No Effect | □ Painful (can do) | □ Painful (limits) | □ Unable to Perform |
| Reading/Concentration | □ No Effect | □ Painful (can do) | □ Painful (limits) | □ Unable to Perform |
| Bathing | □ No Effect | □ Painful (can do) | □ Painful (limits) | □ Unable to Perform |
| Dressing | □ No Effect | □ Painful (can do) | □ Painful (limits) | □ Unable to Perform |
| Sexual Activities | □ No Effect | □ Painful (can do) | □ Painful (limits) | □ Unable to Perform |
| Sleep | □ No Effect | □ Painful (can do) | □ Painful (limits) | □ Unable to Perform |
| Static Sitting | □ No Effect | □ Painful (can do) | □ Painful (limits) | □ Unable to Perform |
| Static Standing | □ No Effect | □ Painful (can do) | □ Painful (limits) | □ Unable to Perform |
| Yard Work | □ No Effect | □ Painful (can do) | □ Painful (limits) | □ Unable to Perform |
| Walking | □ No Effect | □ Painful (can do) | □ Painful (limits) | □ Unable to Perform |
| Other | □ No Effect | □ Painful (can do) | □ Painful (limits) | □ Unable to Perform |

**Webster Technique Acknowledge Form**

I acknowledge that the Webster Technique is a specific chiropractic analysis and diversified adjustment. The goal of the adjustment is to reduce the effects of sacral/pelvic subluxation and/or SI joint dysfunction. In doing so neuro-biomechanical function in the pelvis is improved.

I acknowledge that in a theoretical and clinical framework of the Webster Technique in the care of pregnant women, sacral subluxation may contribute to difficult labor for the mother (i.e., dystocia). Difficult labor is caused by inadequate uterine function, pelvic contraction, and baby mal-presentation. The correction of sacral subluxation may have a positive effect on the causes of difficult labor.

I acknowledge that sacral misalignment may contribute to these primary causes of difficult labor via uterine nerve interference, pelvic misalignment and the tightening of specific pelvic muscles and ligaments. The resulting tense muscles and ligaments and their abnormal effect on the uterus may prevent the baby from comfortably assuming the best possible position for birth.

I acknowledge that this is not a breech turning or in utero-constraint technique

By signing this form, I understand the purpose of the Webster Technique and I agree to have the doctor perform the technique on me at her discretion.

Signature Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Informed Consent for Chiropractic Care**

**Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including x-rays on me (or on the patient named below, for whom I am legally responsible) at **Chiro4All** office.

1. The purpose of chiropractic care is to contribute to health by the location, analysis and correction of vertebral subluxations for the restoration of normal nerve functioning.
2. I understand that I will be examined and cared for by licensed doctors of chiropractic.
3. **Doctor Alae Rabiei** uses only chiropractic methods that are taught in accredited chiropractic colleges, and appropriate techniques will be selected for my spine care based upon standard professional protocols.
4. Chiropractic adjustments are exceedingly safe when applied properly. However, I understand there are some risks to care including, but not limited to, fractures, disk injuries, strokes, dislocations and sprains. I do not expect the doctor to anticipate and explain all of the risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure that the doctor feels at the time, based on the facts known, and in my best interests.
5. I have read, or have had read to me, the above consent. By signing below, I agree to the above-named procedures. I intend this consent form to cover the entire course of care now and in the future. I am free to withdraw my consent and discontinue care at any time.

**Missed Appointment Policy**

We want to thank you for choosing us as your chiropractic health provider. In order to provide you and our other patients with the best optimal spinal care, we request that you follow our guidelines regarding **broken and/or cancelled appointments**. The therapeutic benefit of each visit builds on the previous visit; therefore we discourage cancellations unless absolutely necessary. Please remember that we have reserved appointment times especially for you and these appointments are a commitment for your benefit. If you need to cancel an appointment, we request **at least 24 hours’ notice**. This will enable us to reschedule your appointment and to offer your cancelled time to other patients that desire to get their treatment. When you cancel your appointment at the last minute, everyone loses especially you, the doctor and other patients that would like to have utilized your appointment time.

Unfortunately, due to the recent number of no-shows, we are implementing a no-show policy. In the case of an appointment where the patient does not call to cancel and does not come to the appointment, the office will charge a **no-show fee of $35.00.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_**

**Patient/ Guardian Signature: Date:**