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:

- Chiropractic care for infants & toddlers
- Prenatal yoga
- Prenatal massage
- Prenatal acupuncture
- Pregnancy support belts
- Baby wearing
- Birthing classes
- Doula recommendation
- Midwife recommendation
- OB/GYN recommendation
- Lactation consultant
- Meal planning
- Postpartum emotional wellness
- Other: _____________________
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.

_________________________  ________________________________
Patient Name (printed)            Signature

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? __________________________________________

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 □ Heat □ Rest □ Activity □ Sitting □ Standing □ Medication
____________________________________________________

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

7. What describes the nature of your symptoms?
□ Sharp □ Shooting
□ Dull Ache □ Burning
□ Numb □ Tingling
____________________________________________________

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

9. How are your symptoms changing?
□ Getting Better □ Not Changing □ Getting Worse
________________________________________________________________________________________________________

10. Who else have you seen for your current symptoms?
□ No One □ Medical Doctor □ OB/GYN Provider’s name: __________________________
□ Other Chiropractor □ Physical Therapist □ Midwife
____________________________________________________

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

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

13. What other forms of care have you tried for your current complaint?
□ Nothing □ Muscle Relaxer □ Advil / Tylenol / Aleve (circle) □ Injections
□ Pain Medication □ Ice / Heat (circle) □ Physical Therapy □ Other __________________

14. What do you feel caused your symptoms?
□ Fall □ Lifting □ Work
□ Car Accident □ Don’t Know □ __________________

15. What activities are affected by your symptoms?
□ Work/School (circle) □ Sleeping □ Driving/Riding in Car (circle) □ Golf □ Exercising
□ Walking □ Running □ House Work □ Yard Work □ __________________

LE: __________________________  CL: __________________________
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.

Many of the following conditions respond to chiropractic and acupuncture.

<table>
<thead>
<tr>
<th>16. 17.</th>
<th>PAST</th>
<th>PRESENT</th>
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<tr>
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<td>Headaches</td>
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<td>Diabetes</td>
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<td>Low Blood Pressure</td>
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<td>Excessive Thirst</td>
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<td>Upper Back Pain</td>
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<td>High Cholesterol</td>
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<td>Excessive Uretion</td>
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<td>Mid Back Pain</td>
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<td>Heart Attack</td>
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<td>Hypo-Thyroid</td>
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<td>Low Back Pain</td>
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<td>Chest Pains</td>
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<td>Hyper-Thyroid</td>
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<td>Scoliosis</td>
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<td>Smoking/Tobacco Use</td>
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<td>Shoulder Pain</td>
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<td>Elbow Pain</td>
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<td>Kidney Stones</td>
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<td>Alcohol Dependence</td>
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<td>Wrist Pain</td>
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<td>Kidney Disorder</td>
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<td>Hand Pain</td>
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<td>Bladder Infection</td>
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<td>Depression</td>
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<td>Knee Pain</td>
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<td>Loss of Bladder Control</td>
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<td>Frequent Illness</td>
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<td>Ankle Pain</td>
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<td>Prostate Problems</td>
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<td>Jaw Pain/TMJ</td>
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<td>Abnormal Weight Loss</td>
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<td>Loss of Appetite</td>
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<td>Hot Flashes</td>
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<td>Constipation</td>
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<td>Hormone Replacement</td>
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<td>Osteoporosis/Osteopenia</td>
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<td>Abdominal Pain</td>
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<td>Birth Control Pills</td>
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<td>Ulcer</td>
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<td>Hepatitis</td>
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<td>Ringing in Ears</td>
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<td>Liver Disorder</td>
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<td>Visual Disturbances</td>
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<td>Gall Bladder Disorder</td>
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<td>Cancer</td>
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18. Primary Care Physician__________________________________________ 18b. Date of Last Medical Physical________________________

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

(1) Rheumatoid Arthritis  (2) Heart Problems  (3) Diabetes  (4) Cancer  (5) Lupus  (6) Other: ___________

20. List all prescription and over-the-counter medications, nutritional/herbal supplements 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 (such as concussion, automobile accidents, sports injuries, work-related accidents, etc)...EVEN IF YOU DID NOT HAVE ANY SYMPTOMS OR TREATMENT, STILL NOTE THE TRAUMA PLEASE.
________________________________________________________________________________________________________

________________________________________________________________________________________________________

Patient Signature__________________________________________________________ Date________________________
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 _________________________ Provider __________________________  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  □ Phone □ 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