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:

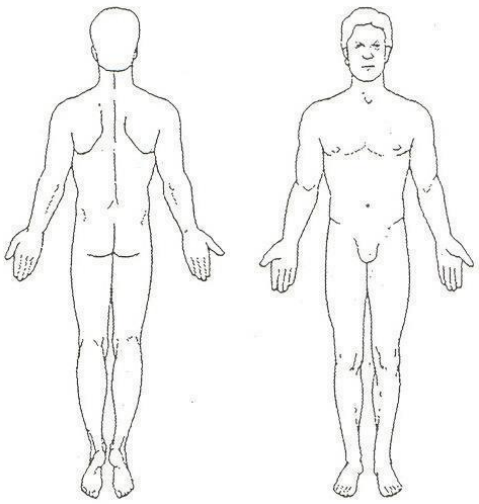
_____
_____
_____
_____
_____

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

Congratulations on your pregnancy! It is important for us to know your PAST history and current GOALS, so please give us some information that will help us to take care of you:

Estimated Due Date_____ I am in my:_____week of pregnancy.

Of Previous Pregnancies: Vaginal _____ C-Section _____ Miscarriage _____

In this pregnancy, have you experienced: □ Use of infertility drugs/In-Vitro Fertilization □ Morning Sickness

□ Pre-Eclampsia □ Other _____ Did you receive the flu shot? _____

Please tell us about any complications if any, you experienced in previous pregnancies:

_____

What birth class have you decided to take (did you take)? □ Bradley □ Hypnobabies/Hypnobirthing □ BabySteps

□ Hospital class □ not yet sure □ none □ other: _____

Where do you plan to give birth? □ Home □ Birth Center □ Hospital Which one? _____

Do you plan to use an Obstetrician or a Midwife? _____

Do you plan to use Doula? _____ If so, who:_____

Are you taking any supplements and/or vitamins? □ Yes □ No If yes, what product(s):_____

What are your hopes or expectations for the birth? □ Natural birth □ Epidural only if necessary □ Definite Epidural

□ VBAC □ Planned C-Section □ Unsure □ Other _____

What is your biggest fear going into this birth? _____

Please circle topics that you would like to hear more about:

□ Doula's □ Creating a Birth Plan □ Chiropractic care for Infants □ Breast Feeding □ Home Birth

□ Birthing Classes □ Circumcision Vaccination Other_____

Name of OB or Midwife: _____Practice Name: _____

Phone: _____

May we have your permission to contact your birth attendant and doula to confer with them and share information regarding the chiropractic care that you are receiving here? □ YES NO

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**