Adult and/or Prenatal Information Form

www.villagefamilychiropractic.com

Village Family Chiropractic

NAME | TODAY'S DATE | BEST PHONE NUMBER TO REACH YOU | TYPE ◯ MOBILE ◯ HOME ◯ WORK

ADDRESS | CITY | STATE | ZIP

EMAIL | DATE OF BIRTH | AGE | HEIGHT | WEIGHT | OCCUPATION

MARITAL STATUS | SPOUSE NAME | CHILDREN | WHO REFERRED YOU

Please skip to Part A on next page if not pregnant

WEEKS PREGNANT | ESTIMATED DUE DATE | NUMBER OF ULTRASOUNDS RECEIVED | LAST AND NEXT APPOINTMENT W/ CARE PROVIDER

Tell us about your birth team (fill in what pertains to you, check what you'd like more information about)

		I'D LIKE TO KNOW MORE ABOUT:
MIDWIFE	CONTACT	◯ MIDWIFE
DOULA	CONTACT	◯ DOULA
OB/GYN	CONTACT	◯ OB/GYN
LACTATION CONSULTANT	CONTACT	◯ LACTATION CONSULTANT
BIRTHING CLASS	INSTRUCTOR	◯ BIRTHING CLASS
PLACENTA ENCAPSULATION	CONTACT	◯ PLACENTA ENCAPSULATION

OTHER

BIRTH LOCATION

◯ HOME ◯ HOSPITAL ◯ BIRTH CENTER ◯ OTHER: _____

BIRTH GOALS WRITTEN?

◯ YES ◯ NOT YET

WHAT IS (ARE) YOUR BIGGEST FEAR(S) ABOUT YOUR PREGNANCY?

Emergency Contact

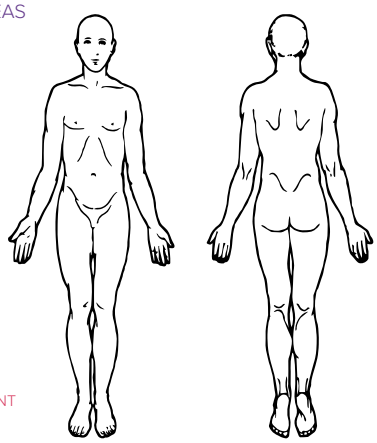
CONTACT NAME | RELATIONSHIP | CONTACT PHONE

Why are you seeking chiropractic care? *If consult is for health and wellness move to Part B*

Part A

WHEN/HOW DID THIS CONDITION BEGIN?

PLEASE CHECK AREAS OF CONCERN:



HAVE YOU HAD IT BEFORE? ◯ YES ◯ NO

IS THIS CONDITION GETTING WORSE? ◯ YES ◯ NO

HOW DO YOU RATE THE CONDITION?

BEST ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 HORRIBLE

WHAT DOES IT FEEL LIKE?

◯ SHARP ◯ DULL ◯ ACHE ◯ NUMB ◯ TINGLE

TIMING OF CONDITION:

◯ CONSTANT ◯ FREQUENT ◯ INTERMITTENT ◯ EPISODIC

WHAT MAKES THE CONDITION BETTER?

WHAT MAKES THE CONDITION WORSE?

WHAT IS THIS CONDITION PREVENTING YOU FROM EXPERIENCING FULLY?

◯ WORK ◯ SLEEP ◯ RECREATION ◯ HAPPINESS ◯ DAILY ACTIVITIES ◯ EVERYDAY LIFE

HAVE YOU SEEN ANYONE ELSE FOR THIS CONDITION? IF SO, WHO?

RESULTS:

IS THE CONDITION:

◯ AUTO ACCIDENT ◯ WORK ACCIDENT ◯ SLIP/FALL ◯ OTHER

DATE OF ACCIDENT

HAS THE ACCIDENT BEEN REPORTED?

Part B

WHAT ARE YOUR CURRENT HEALTH GOALS?

PLEASE MARK ANY THAT YOU HAVE EXPERIENCED IN THE **PAST OR ARE CURRENTLY EXPERIENCING**:

- ◯ Digestive Issues
- ◯ Asthma
- ◯ Allergies
- ◯ Frequently Sick
- ◯ Ear Infections
- ◯ Colic
- ◯ Loss of Appetite
- ◯ Sleep Issues
- ◯ Depression
- ◯ Cancer
- ◯ Anxiety
- ◯ Constipation
- ◯ Extreme Fatigue
- ◯ Joint Pain
- ◯ Dizziness
- ◯ Headaches
- ◯ Numbness/Tingling
- ◯ Decreased Libido
- ◯ Mood Swings
- ◯ Backache
- ◯ Diarrhea
- ◯ Difficulty Concentrating
- ◯ High/Low Blood Pressure
- ◯ Heart Palpitations
- ◯ Food Sensitivity
- ◯ Easy Bruising
- ◯ Seizures
- ◯ Skin irritability/Itchiness
- ◯ Irregular Menstrual Cycles
- ◯ Fertility Concerns
- ◯ Autoimmune Disorders
- ◯ Thyroid Imbalance
- ◯ Hormone Imbalance
- ◯ Night Sweats
- ◯ Hot Flashes
- ◯ ADD/ADHD
- ◯ Sensory Spectrum Disorder
- ◯ Down Syndrome
- ◯ Unexplained Weight Loss/Gain
- ◯ Foggy Thinking
- ◯ Sugar Cravings
- ◯ Ringing in the Ear/s
- ◯ Blindness
- ◯ Deafness
- ◯ Muscle Weakness
- ◯ Suicidal Thoughts
- ◯ Addiction
- ◯ Trauma: _____

LIST ANY SUPPLEMENTS AND/OR MEDICATIONS YOU ARE CURRENTLY TAKING

LIST ANY SURGERIES, ACCIDENTS/INJURIES/BROKEN BONES YOU HAVE HAD

LAST VISIT TO A CHIROPRACTOR | WHERE | FOR | N/A ◯ | CIGARETTES/PACKS PER DAY | ALCOHOLIC DRINKS PER DAY/WK

FAMILY HISTORY

◯ CANCER ◯ HIGH BLOOD PRESSURE ◯ DIABETES ◯ HEART ATTACK ◯ STROKE ◯ OTHER: _____

IS THERE ANYTHING ELSE WE SHOULD KNOW?

I certify that all information provided above is accurate to the best of my knowledge, no information is falsified and I am seeking the help of a healthcare professional on my own free will.

PRINT NAME | **SIGNATURE** | **DATE** | **WITNESS**

Webster Technique Agreement

- ◯ 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 understand that this sacral/pelvic analysis and adjustment may be used on all weight bearing spines: male, female, pregnant or not pregnant.

- ◯ 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(s) of Village Family Chiropractic, INC perform the technique on me at her/his discretion.

PRINT NAME

SIGNATURE

DATE

WITNESS

Informed Consent to Chiropractic Care

THE NATURE OF CHIROPRACTIC CARE:

The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a “click” or “pop”, such as the noise when a knuckle is “cracked”, and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs or essential oils may also be used.

POSSIBLE RISKS:

As with any health care procedure, complications are possible following a chiropractic adjustment. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of care. The ancillary procedures could produce skin irritation.

PROBABILITY OF RISKS OCCURRING:

The risks of complications due to chiropractic care have been described as “rare”, about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered “rare”.

OTHER TREATMENT OPTIONS WHICH COULD BE CONSIDERED MAY INCLUDE THE FOLLOWING:

- Over-the-counter analgesics. The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- Medical care, typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- Hospitalization in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- Surgery in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

RISKS OF REMAINING UNTREATED:

Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes due to subluxation. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and herby give my full consent to treatment at Village Family Chiropractic, INC.

PRINT NAME

SIGNATURE

DATE

WITNESS

Kimberly Snider, DC
HIPPA NOTICE

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient we may use or disclose personal and health related information about you in the following ways:

- Your personal health information including of your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis assessment or treatment.
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, a HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services (cash only entity)
- Your name, address, phone number, and your health care records may be used to contact you regarding scheduling related matters, information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provide to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

- If we are providing health care services to you based on the orders of another health care provider.
- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home, or if you would like the information in a different form please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Request to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and your protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the chances. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose cased on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complain to Village Family Chiropractic, INC.

If you would like further information about our privacy policies and practices please contact Village Family Chiropractic, INC at 336.747.3138.

This notice is effect as of the day you sign and date below. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

PRINT NAME **DATE**

SIGNATURE

If you are a minor, or if you are being represented by another party:

PRINT PERSONAL REP. **DATE**

PERSONAL REP. SIGNATURE

PERSONAL REPRESENTATIVE'S RELATIONSHIP W/ PATIENT