POSNATAL

NAME: DATE:

Date of Birth:

Address:

Email address: Phone Number:

Who can we thank for referring you?

Name: **Phone Number:**

Childbirth Caregiver(s): OB/GYN: Doula Midwife

I gave birth at: Hospital ◯ Birth Center ◯ Other ◯

Name of Hospital or birth center:

How many hours of sleep are you getting each night on average?

How would you rate you overall stress level (circle one)? No stress 1 2 3 4 5 6 7 8 9 10

Are you eating a clean, well-balanced diet (circle one)? Yes No

Did you exercise during your pregnancy (circle one)? Yes No

If yes, what type of exercise?

Any traumas during this pregnancy (circle one)? Yes No If yes, please explain:

Any hospitalizations during this pregnancy (circle one)? Yes No If yes, please explain:

Any medications during this pregnancy, including over-the-counter?

What supplements are you currently taking?

Have you had any chiropractic care during this pregnancy? Please explain

PREVIOUS PREGNANCIES

Number of previous pregnancies: Number of births:

Your previous births were at: Hospital? ◯ Home? ◯ Birth Center? ◯

Medications used in prior births: None/natural ◯ Pitocin ◯ Epidural ◯

Interventions used in prior births: Induced labor/breaking water ◯ Vacuum ◯ Extraction Forces ◯

Episiotomy ◯ Caesarean section ◯ Other:

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 perform the technique on me at her discretion. By signing this form, I also verify that all of my information is correct and that I have completed all questions with as much information as is possible.

Patient's Signature: _____ Date: _____

HIPAA CONSENTS

Name of Practice : Kids Only Chiropractic Address : 14462 S Redwood Road Bluffdale Ut 84065

Privacy Contact : Dr. Matthew Roller D.C. Telephone : 801-290-8966

** I understand that I do not have to sign this authorization in order to receive treatment from this practice, but when my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

NOTICE OF PRIVACY PRACTICE RECEIPT:

I acknowledge that I was provided with the Notice of Privacy Practices of the Chiropractic Practice named at the top of this page.

Printed Name of Patient's parent or Guardian: X

Signature of Patient's parent or Guardiant: X

Date: X

Patient's Date of Birth: X

PATIENT MEDIA RELEASE AGREEMENT (OPTIONAL)

Name of Patients:

1) I authorize the health care professionals who treat me at "Kids Only Chiro" to release and discuss patient information about their treatment or my medical condition, or related topics, (or patient information about their treatment, the medical condition, or related topics, of my child or an individual to whom I provide guardianship.) No special favors, payment or other compensation have been promised to me for agreeing to the authorization. Finally, I understand that the patient information that is released will be current as of the time this authorization is signed.

2) I release Kids only chiropractic and it's spokespeople, from any and all state or federal laws relating to patient privacy.

3) I specifically authorize officials from Kids only chiropractic to share this health information (or that of a child, or an individual to whom I provide guardianship) with members of the news media.

4) I voluntarily give my permission for Kids Only Chiropractic staff to represent me (or my child or an individual to whom I provide guardianship) on video/audio tape, Photograph film or any other medium including social media.

5) I Authorize use of my (or my child or an individual to whom I provide guardianship) name, likeness, voice and biographical material in Kids only Chiropractic publications and website-to include electronic and printed magazines, brochures, newsletters and the internet and its social media (E.G., Facebook, twitter, etc.) - for publicity for the clinic and it's programs.

6) I give "Kids Only Chiropractic" the right to exhibit or distribute such representations in whole or in part, without limitations, for any educational purpose and or research that the clinic, and those acting under its authority, deemed appropriate.

7) I understand that I may withdraw or revoke my authorization at any time and such revocation must be given to Kids only Chiropractic in writing. If I withdraw my permission, my information may no longer be used for release for the reasons covered by this authorization. However I understand that any disclosure or publication made prior to a revocation may remain in the public domain. I further understand that such authorization will not affect my treatment.

Signature of patient: _____ Date: _____