1300 NW Federal Hwy, Stuart FL, 34994
772 780-3037
segurafamilychiro@gmail.com

PRENATAL CHIROPRACTIC INTAKE FORM

PATIENT DATA

NAME: _____ DATE: ___/___/____

Date of birth: ___/___/___

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☐
Caregiver's name and phone number: _____
I plan on giving birth at: Hospital ☐ Birth Center ☐ Home ☐ Other_____
Name of Hospital or Birth Center: _____
What position do you sleep in: Side ☐ Back ☐ Stomach ☐
How many hours of sleep are you getting each night on average? _____
How would you rate your overall stress level (circle one)?
No stress 1 2 3 4 5 6 7 8 9 10 Very stressed _____
Do you drink ½ of your body weight in ounces of water per day (circle one)? ☐Yes ☐No
Are you eating a clean, well-balanced diet (circle one)? ☐Yes ☐No
Are you exercising 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? _____
Any fertility treatment(s)? _____
Have you had any chiropractic care during this pregnancy? Please explain
_____
Any additional information you would like us to know about your pregnancy?
_____

AFTER 32ND WEEK OF PREGNANCY

Position of baby: Headdown ___☐___Posterior ___☐___ Breech or malpositioned ___☐___
Confirmed by: Palpation by: _____ on ___/___/___
Ultrasound by: _____ on ___/___/___
How long do you believe the baby has been in this position? _____

PREVIOUS PREGNANCIES

Number of previous pregnancies:_____ Number of births: _____
Please explain any difference in numbers:
Names and ages of children:
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 ☐ Forceps ☐
Episiotomy ☐ Caesarean section ☐ Other:
How long was your previous labor?
Total: Time before you pushed: Amount of time spent pushing:

Did you receive chiropractic care during your previous pregnancy(s) (circle one)? ☐ Yes ☐ No
Any additional information you would like us to know about your previous pregnancy(s)?

WEBSTER TECHNIQUE AGREEMENT

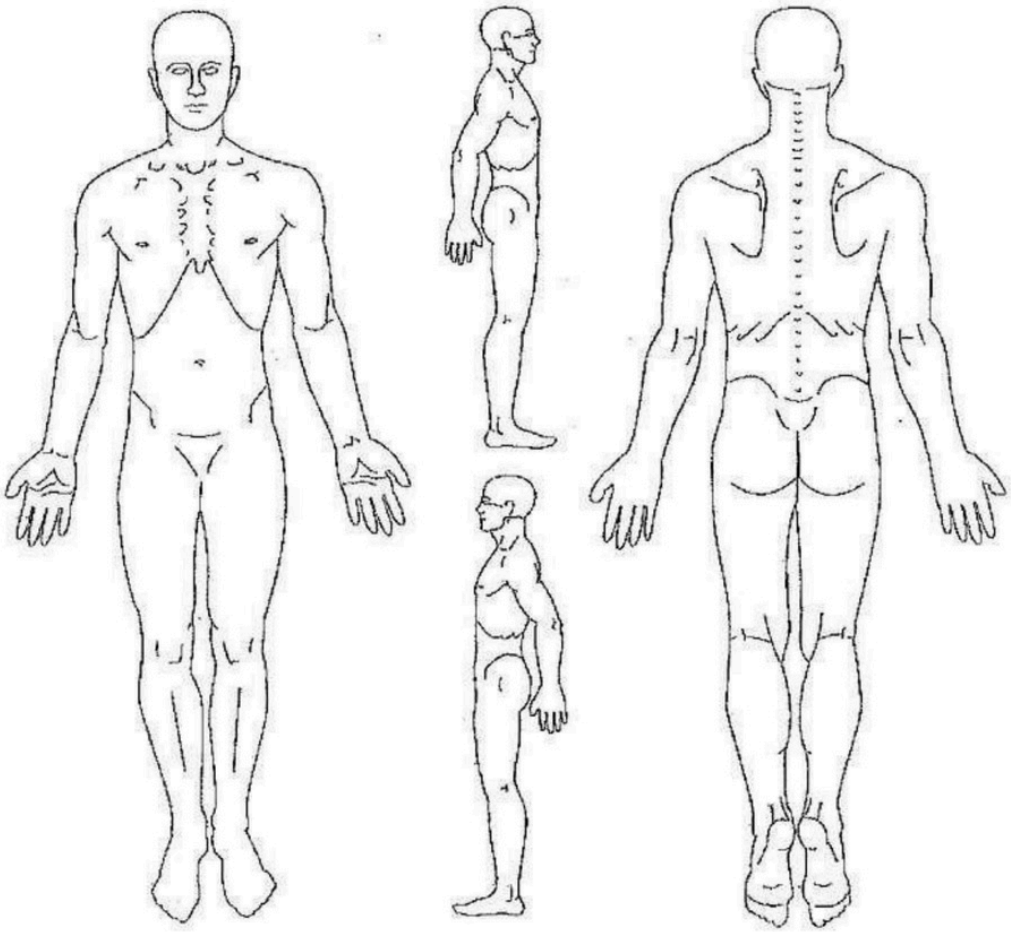
- ☐ I acknowledge that the Webster Technique is a specific chiropractic analysis and diversified adjustment. The goal of the adjustment is to reduce the effects of sacral/pelvic subluxation and/or SI joint dysfunction. In doing so neuro-biomechanical function in the pelvis is improved.
- ☐ I acknowledge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

Patient Signature:_____ Date: _____

Please draw the location of your pain or discomfort on the images below.
Use the symbols shown to represent the type(s) of pain:

D=Dull **B**=Burning **N**=Numb **S**=Sharp/Stabbing **T**=Tingling **C**=Cramping



Please rate your current level of pain by circling a number:

0	1	2	3	4	5	6	7	8	9	10
No Pain		Low		Moderate				Intense		Emergency

Using this scale, over the last 30 days the pain has been:

At Worst

At Best

On Average

PATIENT INFORMATION - PLEASE PRINT CLEARLY AND FILL OUT COMPLETELY

E-mail Address _____

Patient Name _____ Date of Birth _____ Age _____

Street & Mailing Address _____ City _____

State _____ Zip _____ Home Phone _____ Cell Phone _____

Sex: ☐ Male ☐ Female ☐ Married ☐ Single ☐ Widow(er) ☐ Divorced

Current Employer _____

Department _____ Work Phone _____ Ok to call at work? Y / N

Spouse, Partner or Guardian _____ Birth Date _____

Address (if different) _____

Employer _____ Work Phone _____

Emergency Contact (person not living with patient) _____

Relationship to Patient _____ Phone _____

Is this visit because you have you been injured in an accident? ☐ Yes ☐ No Date of Injury? _____

If yes, was the accident work related? ☐ Yes ☐ No Was the injury an auto accident? ☐ Yes ☐ No

Have you hired an attorney because of your injury? ☐ Yes ☐ No

If yes: Attorney's Name _____ Phone _____

If Work-Related: Employer at time of Injury _____ Phone _____

Please Read Carefully:

Financial Policy: Segura Family Chiropractic is a cash-based, out-of-network practice. We do not bill insurance companies. Payment is due at the time of service unless other arrangements have been made in advance.

_____ Patient Initials

I understand that I am responsible for all costs of my care. If I suspend or stop my schedule of care as recommended by my doctor, any fees for services already provided will be due and payable.

_____ Patient Initials

I authorize the release of any medical records necessary to coordinate my care with other physicians directly involved in my care. It is understood that the doctors within this office have access to each other's records.

_____ Patient Initials

I understand that keeping appointments or canceling them with adequate notice prior to my appointment time is my responsibility. Otherwise, I may be charged a regular office visit fee for missed appointments ("no shows").

Date _____ Patient or Guardian Signature _____

Informed Consent

Before beginning treatment, it is our office policy to inform you of what to expect, possible complications of chiropractic, as well as other forms of treatment. Remember that all forms of treatment (including non-treatment) have associated risks. **If you have any questions, please ask the doctor.**

WHAT TO EXPECT

The treatment in our office will consist of manipulation of the joints and soft tissues (muscles and ligaments), using the doctor's hands and/or a mechanical instrument. You may feel movement, and you may hear joint clicks or other noises. Physical therapy methods, including therapeutic exercise, massage and heat or ice may also be used.

CHIROPRACTIC RISKS

Chiropractic treatment is one of the safest methods of treating spinal problems. Still, unexpected problems can occur. Minor, temporary problems such as soreness and stiffness can occur, especially at the start of treatment. More significant problems, such as fracture of a weakened bone or sprain/disc injuries are rare. A stroke following neck manipulation is an extremely rare complication, occurring less than 1 per million treatments. Stroke has also been the result of ordinary activities, such as head turning and sneezing.

OTHER TREATMENTS AND RISKS

There are other forms of treatment used by medical doctors. Their risks include:

Medications: Many commonly used medications such as NSAIDs (Advil, Aleve, and Ibuprofen) carry risks of tissue damage, including stomach ulcers or kidney damage. This damage can occur quickly and may be irreversible. There are significantly higher risks of developing serious complication with NSAIDs compared with chiropractic. The annual number of hospitalizations for serious GI complications related to NSAIDs is estimated to be at least 103,000. Conservative estimates of NSAID-related deaths in the US are 16,500 per year. New England J Med 1999
Other medications are habit forming, and may mask pain to allow further injury or tissue damage.

Surgery: Surgery is the treatment of choice in less than 1% of back pain patients. Your doctor will and continue to screen you for surgical indicators and will refer you for a surgical opinion if necessary. Clinical results of surgery for simple, mechanical lower back pain have been disappointing and may expose you to unnecessary hospital and medication risks.

Rest/ Non-Treatment: Bed-rest has been shown to increase the likelihood of recurrence of back pain episodes, and make chronic pain more likely. Likewise, non-treatment may cause a permanent mechanical problem to develop, causing future back problems.

I have read and understand the above, and give my consent to begin chiropractic treatment.

Printed Name _____ **Date** _____

Signature _____

SEGURA FAMILY
CHIROPRACTIC

772 780-3037
1300 NW Federal Hwy,
Stuart FL, 34994

HIPAA Notice of Privacy Practices

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500. **Other Permitted and Required Uses and Disclosures** will be made only with your consent, **authorization** or opportunity to object unless required by law. **You may revoke the authorization**, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization

Please complete signature on the back of this form

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

You have the right to obtain a paper copy of this notice may from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Please sign the following Acknowledgment Form. Please note that by signing below you are only acknowledging that you have received or given the opportunity to receive a copy of our Privacy Practices.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

Patient Name: _____ **Date of Birth:** _____

Patient Signature/Legal Representative _____

Relationship to Patient _____

Today's Date _____

OFFICE USE ONLY

I attempted to obtain the patients signature in acknowledgment of the Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____