Counts Chiropractic Mobile Care

Webster Technique

Chiropractic care benefits all aspects of your body's ability to be healthy. This is accomplished by working with the nervous system—the communication system between your brain and body. Doctors of Chiropractic work to correct spinal, pelvic, and cranial misalignments (subluxations). When misaligned, these structures create an imbalance in surrounding muscles and ligaments. Additionally, the resulting nervous system stress may affect the body's ability to function optimally.

Sacral misalignment causes the tightening and torsion of specific pelvic muscles and ligaments. It is these tense muscles and ligaments and their constraining effect on the uterus which prevents the baby from comfortably assuming the best possible position for birth.

The Webster Technique is defined as a specific chiropractic analysis and adjustment that reduces interference to the nervous system and facilitates biomechanical balance in pelvic structures, muscles and ligaments. This has been shown to reduce the effects of intrauterine constraint, allowing the baby to get into the best possible position for birth.

Dr. Larry Webster, Founder of the International Chiropractic Pediatric Association (ICPA) discovered this technique as a safe means to restore proper pelvic balance and function for pregnant mothers. In expectant mothers presenting breech, there has been a high reported success rate of the baby turning to the normal vertex position. This technique has been successfully used in women whose babies present transverse and posterior as well. It has also been successfully used with twins. Any position of the baby other than ROA may indicate the presence of sacral subluxation and therefore intrauterine constraint. At **no** time should this technique be interpreted as an obstetric, "breech turning" technique.

It is strongly recommended by the ICPA instructors of this technique that this specific analysis and adjustment of the sacrum be used throughout pregnancy, to detect imbalance and optimize pelvic biomechanics in preparation for safer, easier births. Because of the effect the chiropractic adjustment has on all body functions by reducing nerve system stress, pregnant mothers should have their spines checked regularly throughout pregnancy, optimizing health benefits for both the mother and baby.

Dr. Telli L. Counts is a *Certified Webster Technique Practitioner* and a member of the *International Chiropractic Pediatric Association, ICPA.*

Please sign to acknowledge that you understand the above description of the Webster technique:

Name: ____

Signature: ____

Date: ____

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CONFIDENTIAL PREGNANCY PATIENT CASE HISTORY

Please complete this questionnaire fully and remember to bring it with you for your first appointment. Your answers will help us determine how chiropractic care can help you.

PERSONAL INFORMATION:

Name: ____ Referred by: ________________________________

Previous Chiropractic Care? _______________________ When was your last adjustment? _____________

The human body is designed to be healthy. The primary system in the body which coordinates health is the nervous system. The healthy function of every cell, every system, and every organ is dependent upon the integrity of the nervous system. The bones of the skull and vertebrae of the spine house and protect the central nervous system.
From the birth process until the present, events have occurred in your life which may have caused interference and damage to this delicate system. Physical, emotional, and chemical stresses common to our contemporary lifestyles can result in misalignment and damage to the spinal column. This interference is called the Vertebral Subluxation Complex.
The following form will help reveal the causes of Vertebral Subluxation which interfere with the optimal function of your nervous system and therefore impair your inborn health and well -being.

PRENATAL HISTORY:

1. Is this your first pregnancy? ____

2. How many other births have you had? ____

3. How many weeks pregnant are you now? ____

4. Due Date ___________________________

5. Have you experienced any traumas (accidents, falls) during this/past pregnancy? _____________
Please describe: ____

6. Any medications taken during this pregnancy? ____

7. Do you smoke or drink alcohol? ____

8. Have you had any evaluation procedures (ultrasound, amniocentesis, chorionic villus sampling)?
____

9. Please list dates, frequency and reason for these procedures:
____

10. How has your diet been during this pregnancy? Poor Fair Good Great Excellent

11. Do you take supplements? _______________ If yes, what are you taking? ____________________
____

12. How much water are you drinking per day? _________Glasses or _____________ Ounces

13. Have there been any stressful events in your life during this pregnancy? _____________________

____

14. What are your most significant fears associated with this birth? ____________________________

____

15. Who is your birth care provider? ____

16. Will you have someone with you at birth for support (other than birth care provider)? _________
Please specify who: ____

17. Where do you plan on delivering? ____

18. Have you put together a birth plan? ____

PREVIOUS BIRTH HISTORY

Please print & complete this page for each previous delivery

Baby's Name: ______________________________ **Date of Birth:** _________________________________

Weight: ________________________ Length: _______________ APGAR: __________________________

Place of Birth: Hospital / Birthing Center / Home

Delivering Practitioner: OB/Gyn / Certified Nurse Midwife / Certified Practicing Midwife / Lay Midwife

Position of Delivery: Lithotomy position (on back with feet up) / On your side / Kneeling / Squatting / Other:____

Was labor induced? Y / N ________________________________

If yes specify: Pitocin / Prostaglandin Gel / Unknown____

Were your membranes ruptured by your care provider? Y / N

Were contractions stimulated intravenously with Pitocin once labor started? Y/N________________________

Did you receive any pain medication or anesthesia? Y / N
____

Epidural? Y / N
How many cm were you dilated when it was administered? ________________________

Did you experience back pain during labor? Y / N

Did you deliver vaginally? Y / N

Baby presentation at time of delivery: Normal / Posterior / Facial / Breech

If breech specify: Footling / Frank / Complete / Kneeling
____

Did your care provider assist delivery with his/her hands? Y / N

Was there any turning of the neck or traction / pulling applied to the neck? Y /N

Were operative devices used to facilitate the birth? Y / N
Which type? Forceps / Vacuum Extraction
____

If yes, were there any visible signs of injury to your baby? Y / N

If yes, where was the injury sustained? ____

Was there a birthing coach present? Husband / Doula / Friend / Other: __________________________________

At what week of pregnancy was your baby born? ____

Other information that may be specific to the birth:

____

____

____

____

____

____

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CHIROPRACTIC INFORMED CONSENT TO TREAT

We believe that our patients should be active participants in their care. Please feel free to ask any questions about your treatment so that you may continue to make informed, responsible decisions regarding your health care. In addition, we encourage patients to discuss their treatment with their primary care physician. Just as the body works as an integral whole, so must the people who help you to care for it.

_____ (*initial*) We do not offer to diagnose or treat any disease or condition other than vertebral subluxation (spinal misalignment). However, if during the course of chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health provider who specializes in that area.

_____ (*initial*) You have the right to be informed about your condition and the recommended procedure(s) to be used so that you can make an informed decision whether or not to undergo the procedure after knowing the risks and hazard involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure. Doctors of Chiropractic, Medical Doctors and Physical Therapists using manual therapy treatment in the cervical spine (neck) are required to explain that there have been rare cases of injury to a vertebral artery as a result of treatment. Such an injury has been known to cause a stroke, sometimes with serious neurological damage. The rare chance of this happening is estimated to be approximately from 1 per 400,000 treatments to 1 per 10 million treatments. Appropriate tests will be performed to help identify if you may be susceptible to this type of injury; you will be notified if that is the case. If you have any questions about this, please do not hesitate to speak with your practitioner. As with any health procedure, complications may arise during treatment. These complications include soreness, muscle/ligament strain, dislocations, fractures, or disk injuries. These are *extremely* rare occurrences.

_____ (*initial*) I hereby request and authorize the performance of diagnostic tests, procedures and treatment deemed necessary by personnel involved in my care. I consent to the performance of chiropractic adjustments and other procedures within the scope of chiropractic practice within the State of SC on me (or on the patient named below, for whom I am legally responsible) by the chiropractor(s) named below and/or other licensed chiropractor who now or in the future treat me while employed by, working or associated with or serving as back-up for the chiropractor named below, whether signatories to this form or not.

_____ (*initial*) I understand that methods of treatment may include, but are not limited to chiropractic adjustments, kinesio-taping/ Rock-Tape, Graston/myofascial/trigger point therapy, herbal medicine and nutritional counseling. The nutritional supplements, essential oils, or homeopathic remedies that have been recommended are traditionally considered safe. Supplements may have side effects including, but not limited to, gastrointestinal disturbances, headache, and rashes. I will notify my practitioner of any side effects associated with the consumption of the recommended supplements.

_____ (*initial*) I do not expect my provider to be able to anticipate and explain all possible risk and complications of the treatment, and I wish to rely on my provider to exercise judgment during the course of treatment. I understand that results are not guaranteed.

_____ (*initial*) I understand that it is my responsibility to inform my practitioner if I am pregnant or believe I may be pregnant.

Authorization to Treat a Minor (under the age of 18)
I hereby request and authorize my doctor at this clinic to perform diagnostic tests and render chiropractic adjustment and other treatment to my minor son/daughter. As of this date, I have legal right to select and authorize health care services for the minor child named above. Under the terms and conditions of my divorce (if applicable), separation or other authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in anyway, I will immediately notify Dr. Telli Counts. By signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of chiropractic adjustments and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

____
Print Name Signature

____
Patient Representative

____
Date

Counts Chiropractic Mobile Care
WELCOME

People today juggle an incredible number of responsibilities: jobs, children, friendships, relationships, errands, appointments - the list is endless! You've got to be healthy just to keep up! We are pleased to welcome you to Counts Chiropractic Family and Wellness Center, LLC., and are thankful you have chosen us to partner with you in restoring and maintaining optimal health.

The Clinic
Counts Chiropractic Family and Wellness Center, LLC. specializes in pregnancy, pediatric, and family wellness chiropractic care. We also offer nutritional supplements, kinesio-tape/Rock-tape, and Graston (myofascial therapy). Care is provided by Dr. Telli Counts (owner). Dr. Counts state licensed chiropractors by the SC Board of Chiropractic Examiners. Dr. Counts has additional training through the International Pediatric Chiropractic Association (ICPA) for those protocols and techniques specific to pregnant and pediatric populations.
We are available, on-call, for home, hospital, or birth center visits ~ ask for details!

Payment
Payment is due at the time of service. We accept cash, checks, credit card and Health Savings Account (HSA) cards. Our new client fee is $75.00. If additional family members schedule as a new patient within 30 days their new client fee is $55.00. Emergency visits outside of office hours or off location (labor visits) will be charged at the rate of $125 per visit within a 20 mile radius. Standard mileage fees outside 20 mile radius will be charged.

Cancellation Policy
As a courtesy to all of our patients, we strive to maintain a smooth and efficient operation so that you can enjoy your treatment on time, all of the time. Since our services are by appointment only, please make yourself familiar with our cancellation policy:

- 24 hour notice is **required** for cancelling or rescheduling an appointment to avoid charges.
- A no call/no show will result in a $50.00 charge, including new patients.
- Emergencies and certain exceptions (labor and delivery) can be made on a case by case basis, but must be done by phone **before** the appointment.
- A no show/no call charge must be paid before another appointment will be scheduled or administered.

We greatly appreciate your business and thank you deeply for your cooperation with this policy.

HIPAA
The Health Insurance Probability & Accountability Act (HIPAA) of 1996 is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, the right to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared an explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your information. Counts Chiropractic Family and Wellness Center's HIPAA privacy policies are available to read and print on our website. Please ask if you would like a copy to read upon your visit to our clinic.

Please date, sign and print your name below to acknowledge that you have read and understand Counts Chiropractic Mobile Care's Practice Information, Cancellation Policy, and Notice of Privacy Practices.

____
Print Name

____
Signature

Date