Hardwick Chiropractic
54 School Circle
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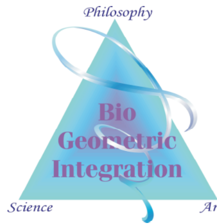
802.472.3033



Dr. Grace Johnstone
Dr. Rick Eschholz
Dr. Teri Dodge

Please fill out completely and answer all questions to the best of your ability.

Name: ____ Home Phone: ______________________________

Address: ______________________________________ Business Phone: ____________________________

City: _________________ State: _______ Zip: _________ Email address ______________________________

Date of Birth: __________ Age: ____ M____ F____ Married_____ Partnership______ No. Of Children______

Social Security Number: ____________________ Insurance: ______________________________________

Occupation: ____

How did you hear about our office? ____

Personal History

Have you ever had your spine or nervous system examined professionally? ____________________________

If yes, when, and by whom? ____

Have you ever received chiropractic adjustments by a Doctor of Chiropractic? __________________________

If yes, when was your last visit? ____

For how long were you receiving chiropractic adjustments? ____

How often did you go? ____

If you stopped, why did you stop going? ____

Do you know what type of adjustments the doctor performed, or what technique (s) or methods she/he used?

____

Were you pleased with his/her service? ____

Does your immediate family receive chiropractic adjustments? _______________________________________

What do you hope to receive at our office? ____

The practice of chiropractic is based upon the location and adjustment of subluxations. Subluxations are caused by any stress that your body is unable to adapt to and use. These stresses may be ***physical****,* ***chemical****, or* ***emotional*** *in nature.*

Physical Stress

Birth History :

My birth was: at home _______ in a birthing center _______ in a hospital _______

Were you incubated or isolated after birth?____________________________________

Was your mother outwardly ill prior to pregnancy with you? Yes___ No___

Did your mother have a difficult pregnancy with you? Yes___ No___

Did your mother have any falls, accidents, or physical injuries during pregnancy? Yes___ No___

Was your delivery traumatic? Yes___ No___

Was there any physical or mechanical stress to you or mother
as labor progressed, during delivery, or as a newborn? Yes___ No ___

Check any that may apply to your delivery:

Drug induced ___ forceps or suction___ c-section__ cord around neck___ breech___ prolonged___

General Physical Trauma

Were you ever knocked unconscious? Yes___ No ___

If yes, when and how?____

Have you ever used crutches, a walker, or cane? Yes___ No___

If yes, when and why?____

Have you ever had any impacts, falls, or jolts that you feel specifically may have injured your spine?
Yes___ No___

If yes, when and how?____

Have you had extensive dental work performed? Yes___ No___

Orthodontal work? Yes___ No___

During the day I: Sit___ stand___ walk___ do desk work___ phone work___ drive___
do mechanical work___ heavy lifting ___ other ____

Sports and Leisure

I exercise: daily ___ weekly___ monthly ___

What sports are you active in? ____

Have you been hurt in any of these activities?_____________________________________

Comments:____

Automobile Accidents

Have you, even as a passenger, even if you do not think you were hurt, been involved in a vehicle collision/ near collision (motorcycle, snowmobile, plane, etc.)? Please list approximate dates and describe resulting injuries: ______________________________

____

____

Please list any remaining issues you have as a result of these injuries:

____

____

Medical Treatment

Have you ever been hospitalized? Yes___ No___

When and why? ______________________________

____

Have you had surgery? When?

____

Do you still have all your body parts?______________________________

How do you assess your physical health?

Excellent ___ Good ___ Fair ___ Poor ___ Getting better___ Getting worse___

If you consider yourself ill, why do you feel you are ill?

____

If you consider yourself well, why do you feel you are well?

____

Pain Assessment

Constant Daily Intermittent With Activity Occasional Other________

Level of pain initially: 1 2 3 4 5 6 7 8 9 1 0

<least more>

Level of pain presently: 1 2 3 4 5 6 7 8 9 1 0

Site of pain: ______________________________

Description of pain: ______________________________

How and when did this start: ______________________________

Has the frequency or intensity changed? ______________________________

Is there anything else that may help us better understand you?

____

R:

tx:

re sx:
HA
Teeth clenching/grinding
Balance problems
Dizziness
Sinus, colds
Earaches
Hand/arm numbness
Nausea
Depression
Anxiety
Asthma
Sleep disorders
CFS
Filmomyalsia
Knee/ankle problems
Foot/leg numbness

Chemical Stress

Was your mother regularly taking any drug during her pregnancy with you? _____Alcohol____ Smoking____

Was her labor chemically induced or altered? Yes___ No___

Was your mother: conscious___ semi-conscious___ unconscious___ during your delivery?

Please list any other chemical stress that your mother may have been subject to:

____

Please indicate how much of the following you consume:

	Type	Never	Seldom	Often
Tobacco				
Alcohol				
Coffee				
Recreational Drugs				

Are you now taking any medications (prescription or over-the counter)?
What medications are you taking: To treat: For how long?

______________________ ______________________ ______________________

______________________ ______________________ ______________________

______________________ ______________________ ______________________

______________________ ______________________ ______________________

Were you previously taking any medication regularly?____

Do you work with any chemical, fume, dust, powder, or smoke for prolonged periods? _______________

Emotional Stress

With each of the following stresses, please check either “P” for past or “C” for current if applicable.

	Mild		**Moderate**		**Extreme**			**Mild**		**Moderate**		**Extreme**	
	P	C	P	C	P	C		P	C	P	C	P	C
Childhood Stress							Work-related stress						
School Stress							Stress of commuting						
Play/Recreation							Loss of loved one						
Family Stress							Change in lifestyle						
Personal Relationships							Change in vocation						
Stress of Sickness							Abuse						

How do you assess your emotional-mental health?

Excellent ___ Good ___ Fair ___ Poor ___Getting better___ Getting worse___

MUTUAL AFFIRMATION OF PURPOSE
&
FINANCIAL RESPONSIBILITIES AND INSURANCE RELEASE AUTHORIZATION

As a chiropractor, I recognize that all living things possess an innate intelligence, which orchestrates all healing, growth and learning for that individual. I recognize that subluxations interfere with these transmissions, thus interfering with the proper functioning of the organism. When released, the potential stored within subluxations leads to greater ease and increased awareness. I choose to help people express bettesr health by detecting and correcting these subluxations. I recognize that the presence or absence of symptoms or dis-ease is not necessarily an indication of the quality of health, nor is it an indication of the presence of subluxations.

I recognize that symptoms are a part of an intelligent process, serving both as integral parts of the healing mechanism, and as signals to alert the individual of the need for change. I do not treat symptoms, conditions, or ailments other than subluxations. I will not venture into the practice of medicine by advising about the need for alterations of medications. I suggest you speak with your medical physician to determine the objective and goal to be obtained by receiving the medical treatment. Determine if this is consistent with your desire for wellness at this point and time. Your medical physician may guide you in changing any medication or treatments you are taking to accommodate for your changing body-mind.

Consistent with these concepts, I choose to help each individual member of my practice to a greater level of wellness, empowerment, and healing by locating and adjusting with whatever technique appears most honoring to that individual.

Sincerely,

Grace Johnstone, D.C.
Rick Eschholz, D.C.
Teri Dodge, D.C.

I have read this statement of purpose and understand its contents. I understand that the adjustments offered in this office are not a replacement for diagnosis or treatment provided by other types of practitioners. I understand that I am not being treated from any condition or symptom other than subluxations. I therefore accept chiropractic care on this basis.

I assume full responsibility for paying for the care and services I receive here should my insurance company, for any reason, elect not to pay. I have read and understand the fee schedule offered at this office.

Additionally, I authorize the release of any medical or other information necessary to process this claim.

Signature: ____ Date: ___________________________

CONSENT TO TREATMENT OF A MINOR

I hereby authorize Dr. Grace Johnstone, Dr. Rick Eschholz, and Dr. Teri Dodge to administer treatment, as she/he deems necessary for____.

Guardian's Signature: ____ Date: ___________________________

Witnessed: ____