

Hardwick Chiropractic

Gentle, Life Changing Healthcare

Dr. Grace Johnstone

Dr. Rick Eschholz

54 School Circle • East Hardwick, Vermont 05836 • 802-472-3033 • 802-472-3022 fax • www.hardwickchiropractic.com

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

Name _____

Date _____

Address _____

Home Phone _____

City _____ State _____ Zip _____

Business Phone _____

Email _____

Cell Phone _____

Date of Birth _____ Age _____ Male Female

Married Partnership # of Children _____

Social Security Number _____

Occupation _____

Insurance _____

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? Explain _____

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.*

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? Yes No

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 _____

Severity of complaint or level of pain at onset:

1 2 3 4 5 6 7 8 9 10
(low/less high/more)

Severity or level of pain presently:

1 2 3 4 5 6 7 8 9 10
(low/less high/more)

Site of Pain _____

Description of Pain (i.e. burning, aching, etc...) _____

How and when did it start? _____

How has the frequency or intensity changed? _____

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

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

Chemical Stress

Was your mother regularly taking any drug during her pregnancy with you? Yes No
 Alcohol? Yes No Smoking? Yes No

Was her labor chemically induced or altered? Yes No

During delivery, my mother was: conscious semi-conscious unconscious

Please list any other chemical stress that your mother may have been subjected to.

Please indicate how much of the following you consume.

	Type	Never	Seldom	Often
Tobacco				
Alcohol				
Coffee				
Recreational Drugs				

Are you taking any medications (prescription or over-the counter)? Yes No

List medication(s): _____ To treat: _____ Duration/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

Comments: _____

**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 better 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.

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 insurance claims.

Signature _____ Date _____

CONSENT TO TREATMENT OF A MINOR

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

Guardian's Signature _____ Date _____

Witnessed by _____