



Dr. Grace Johnstone • Dr. Rick Eschholz • Dr. Sara Crandall

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 _____ Married Partnership # of Children _____
Gender _____ Preferred Pronoun/s _____
Social Security Number _____ Occupation _____

Insurance _____ *Please allow us to make a copy of your insurance card*

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.*

Physical Stress

Birth History

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

Were you incubated or isolated after birth? Yes No

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

Orthodontic work? Yes No

During the day I: Sit Stand Walk Drive Other _____

During the day I am: At my Desk On the Phone 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? 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
Alcohol				
Coffee				
Recreational Drugs				

Allergies: None Please list: _____

Do you have an active diagnosis of hypertension? Yes No

Smoking: Daily Some days Former smoker Never smoked

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

**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.
Sara Crandall, 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. We may charge interest on balances that are 30 days or more overdue. This is computed at the rate of 1 ½ % per month (18% APR) on the total amount owed.

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 the physicians at Hardwick Chiropractic to administer treatment, as she/he deems necessary to _____.

Guardian's Signature _____ Date _____

Witnessed by _____

Consent For Use or Disclosure of Health Information

Our Privacy Pledge

Hardwick Chiropractic is very concerned with protecting your privacy. While the law requires us to give you a copy of this disclosure, please understand that we have, and always will, respect the privacy of your health information. There are several circumstances in which we may have to use or disclose your health care information.

We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.

We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.

We may need to use your health information within our practice for quality control or other operational purposes.

We may send you correspondence in the form of postcards, birthday cards, thank you letters, health information, monthly newsletters, and other information. We may also send gift certificates for referring others patients to us. You have the right to refuse such correspondence.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (§ 164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy practices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Appointment Reminders

Your chiropractor and member of the practice staff may need to use your name, address, phone #, e-mail and clinical records to contact you with appointment reminders, information about treatment alternatives or other health related information. If this contact is made by phone and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice.

Print Name

Signature

Date

Authorized Provider Representative

Date

Communication by Email, Text Message, and Other Non-Secure Means

It may become useful during the course of treatment to communicate by email, text message (e.g. "SMS") or other electronic methods of communication. Be informed that these methods, in their typical form, are not confidential means of communication.

If you use these methods to communicate with Hardwick Chiropractic/ Community Hyperbaric there is a reasonable chance that a third party may be able to intercept and eavesdrop on those messages. The kinds of parties that may intercept these messages include, but are not limited to:

- * People in your home or other environments who can access your phone, computer, or other devices that you use to read and write messages.
- * Your employer, if you use your work email to communicate with Hardwick Chiropractic/Community Hyperbaric.
- * Third parties on the Internet such as server administrators and others who monitor Internet traffic.

CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY NON-SECURE MEANS

I _____ consent to allow Hardwick Chiropractic/Community Hyperbaric to use unsecured email and mobile phone text messaging to transmit to me the following protected health information:

- * Information related to the scheduling of meetings or other appointments
- * Information related to billing and payment

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this consent at any time by giving written notice to Hardwick Chiropractic/ Community Hyperbaric at the above address.

Signature: _____ Date: _____