Hardwick Chiropractic
Gentle, life changing health care
and
Hyperbaric Center

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

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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 _____

Age _____ Date of Birth _____ Married ❑ Partnership ❑ # of Children ___

Gender _____ Preferred Pronoun/s _____ Occupation _____

Social Security Number _____

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

Are you here because of an auto accident or on the job injury? ❑ No ❑ Yes

Who can we thank for referring you to Hardwick Chiropractic and Hyperbaric Center?
❑Family ❑Friend ❑Healthcare Provider ❑Advertisement ❑Web Search
Please provide name so we may thank them _____

*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.*

Health History

Have you received chiropractic adjustments by a Doctor of Chiropractic this year? _____
If yes, when was your last visit? How many times did you go? _____
Have you seen anyone else for this problem?
❑Primary Care Physician ❑Massage Therapist ❑Physical Therapist -How many visits this year? _____
What do you hope to receive at our office? _____

My birth was: ❑ at home ❑ in a birthing center ❑ in a hospital
❑ Drug Induced ❑ Forceps or Suction ❑ C-section ❑ Cord Around Neck ❑ Breech ❑ Prolonged

Were you incubated or isolated after birth?	❑ No	❑ Yes
Was your delivery traumatic?	❑ No	❑ Yes
Was there any physical or mechanical stress to you or mother during pregnancy, as labor progressed, during delivery, or as a newborn?	❑ No	❑ Yes

Have you experienced significant trauma in the past? ❑ Mental ❑ Emotional ❑ Physical

Please describe _____

How do you assess your emotional-mental health?

❑ Excellent ❑ Good ❑ Fair ❑ Poor ❑ Getting Better ❑ Getting Worse

Were you ever knocked unconscious? ❑ No ❑ Yes

If yes, when and how? _____

Have you ever used crutches, a walker, or cane? ❑ No ❑ Yes

If yes, when and why? _____

Have you ever had any impacts, falls, or jolts that injured your spine? ❑ No ❑ Yes

If yes, when and how? _____

Have you had extensive orthodontic work performed? ❑ No ❑ Yes

I exercise: ❑ Daily ❑ Weekly ❑ Monthly

Comments: _____

Please indicate how often you consume the following:

Alcohol: ❑Never ❑Seldom ❑Often

Recreational Drugs: ❑Never ❑Seldom ❑Often

Allergies: ❑ None ❑ Please list: _____

Smoking: ❑ Daily ❑ Some days ❑ Former smoker ❑ Never smoked

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

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

_____

Automobile Accidents/ On-the-Job injury

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.)?

Dates: _____

Description of Accident: _____

Resulting injuries: _____

Medical Treatment

Have you ever been hospitalized? ❑ No ❑ Yes
When and why? _____

Have you had surgery? ❑ No ❑ Yes Date: _____ Procedure: _____

Result: _____

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

_____

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

_____

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

List medication(s):	To treat:	Duration/For how long?
_____	_____	_____
_____	_____	_____
_____	_____	_____

Were you previously taking any medication regularly?_____

Please check if any immediate family members have the following:

❑ Rheumatoid Arthritis ❑ Diabetes ❑ Arthritis ❑ Heart problems ❑ Cancer ❑ Back pain

For each condition listed below, please circle if you have had in the past or are currently experiencing:

(P=past, C=current)

P C	P C	P C	P C
❑❑Arthritis	❑❑Kidney/Bladder Disorders _____	❑❑ Fatigue	❑❑ Diabetes
❑❑ Cancer	❑❑ Loss of Bladder Control	❑❑ Chronic Fatigue	❑❑Drug/Alcohol Dependence
❑❑Asthma	❑❑ Prostate Problems	❑❑ Muscular Incoordination	❑❑Depression/ Anxiety
❑❑Dizziness	❑❑Abnormal Weight Gain/Loss	❑❑ Lyme/Tick Born Disease	❑❑ Lupus
❑❑Nausea	❑❑Loss of Appetite	❑❑Fibromyalgia	❑❑ Epilepsy
❑❑Sleep disorder	❑❑Abdominal Pain	❑❑ Acid Reflux	❑❑Dermatitis/Eczema/ Rash
❑❑High Blood Pressure	❑❑Hepatitis	❑❑TMJ/clenching/ grinding	❑❑ HIV/AIDS
❑❑Heart Attack/Heart Disease	❑❑Liver/ Gallbladder Disorder	❑❑Autoimmune disorder	❑❑ MS
❑❑ Stroke			

What brings you in today? Please use a new line for each complaint

Primary Pain/Symptom

Site of pain/symptom:

_____

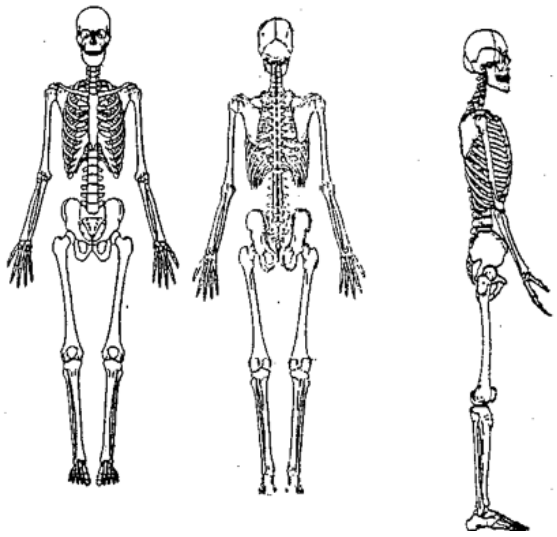
How and when did it start?

_____

What makes it worse? _____

What makes it better? _____

Please indicate where you are experiencing symptoms



Severity or level of pain/ symptom

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

How is this affecting you?

❑ Physically ❑ Mentally ❑ Emotionally

❑Constant ❑Daily ❑Intermittent ❑With/After activity

❑Burning ❑Aching ❑Shooting ❑Numbness/tingling

How has the frequency or intensity changed? _____

Secondary Pain/Symptom

Site of pain/symptom: _____

How and when did it start? _____

What makes it worse? _____What makes it better? _____

Severity or level of pain/ symptom

(low) 1 2 3 4 5 6 7 8 9 10 (high) **How is this affecting you?** ❑ Physically ❑ Mentally ❑ Emotionally

❑Constant ❑Daily ❑Intermittent ❑With/After activity or movement ❑Burning ❑Aching ❑Shooting

❑Numbness/tingling

How has the frequency or intensity changed? _____

Other Pain/Symptom

Site of pain/symptom: _____

How and when did it start? _____

What makes it worse? _____What makes it better? _____

Severity or level of pain/ symptom

(low) 1 2 3 4 5 6 7 8 9 10 (high) **How is this affecting you?** ❑ Physically ❑ Mentally ❑ Emotionally

❑Constant ❑Daily ❑Intermittent ❑With/After activity ❑Burning ❑Aching ❑Shooting

❑Numbness/tingling

How has the frequency or intensity changed? _____

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 other 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	_____ Authorized Provider Representative
_____ Signature	_____ Date
_____ 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:_____