Hastings Chiropractic

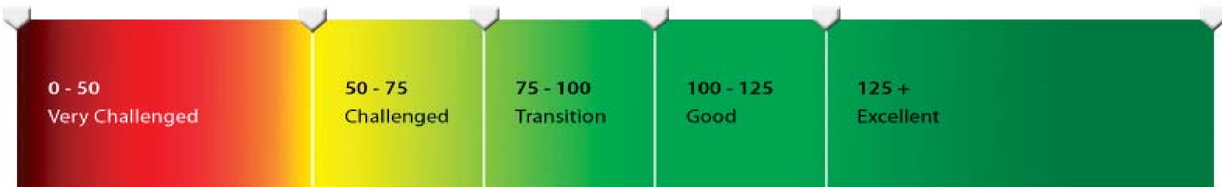
Main Street, Burton House
PO Box 1078 Norwich, VT 05055
802.295.4800
Email: drchastings@hotmail.com
Web address www.hastingschiropractic.com

PERSONAL INFORMATION:

Name: ____Age:______
Date: ________________Address: ______________________________
City/State/ Zip: ____________________________Home Phone #: (__)____-______
Work Phone #: (__)____-______ Cell Phone #: (__)____-______
Email Address: _________________________ Male _____ Female: _____
DOB:____________ Social Security Number _________________
Occupation: ___________________
Employer Name And Address:_________________________
Best Time To Contact: _____________________
Status: Single Married Divorced Widowed

# of Children, Names and
Ages:____
____
_

YOUR HEALTH:



*Please place an (X) on the scale above marking where you believe your level of health and wellness is at this time. Place a circle (o) on the diagram indicating where you would **like** your health and wellness to be.*

YOUR HEALTH PROFILE:

What brings you into our office? Please briefly describe your chief concern, including the impact it has had on your life. If you have no symptoms or complaints and are here for Chiropractic Wellness Services, please skip to the .General History page.

Health Concerns:	Rate Severity 1 = mild 10= worst imaginable	When did this start?	Are symptoms Constant or intermittent?	Did problem begin with injury?

Hastings Chiropractic

Since the problem started, it is.____The Same _____Getting Better _____Getting Worse

What makes the problem worse?

____

____

What, if anything makes it feel better?

____

____

Does this interfere with your: ____Work ____Leisure ____Sleep ____Sports ____Other:____

____

Have you seen other doctors for this condition? ___Chiropractor ___ Medical Dr ___Other

Name/ Address:

____

Date: _______________________________What was diagnosis? ____________________

Name/ Address:

____

Date: ________________________________What was diagnosis? ____________________

General History:

List all medications you are taking and why: (Prescription and non-prescription)

____

____

Have you had any surgeries or hospitalizations? (Please include all surgeries)

____

____

____

____

____

____

What do you do for a living?

____

Have you ever had any work related injuries?

____

Hastings Chiropractic

Have you ever had any slips, falls or auto accidents?____
____

Please check (✓) all symptoms you have ever had, even if they do not seem related to your current problem:

__ Headaches __ Pins and needles in legs __ Fainting __ Neck pain
__ Pins and needles in arms __ Loss of smell __ Back Pain __ Loss of balance

__ Dizziness __ Buzzing in ears __ Ringing in ears __ Nervousness

__ Numbness in fingers __ Numbness in toes __ Loss of taste __Stomach Upset

__ Fatigue __ Depression __ Irritability __ Tension

__ Sleeping problems __ Stiff Neck __ Cold Hands __ Cold Feet

__ Diarrhea __ Constipation __ Fever __ Hot Flashes

__ Cold Sweats __ Lights bother eyes __ Urinary Problem __ Heartburn

__ Mood Swings __ Menstrual Pain __ Menstrual Irregularity __ Ulcers

On a scale of 1-10 describe your psychological/emotional stress levels:
(1= none/ 10=extreme)
Occupational:
____

Personal:
____

On a scale of 1-10, (1 being very poor and 10 being excellent) describe your:

Eating habits: _____Exercise habits:_____ Sleep: _____ General Health: _____
Mind-set:_____

YOUR GOALS: At our office we concern ourselves with YOUR health and YOUR wellness goals.
Please list your goals for your health and wellness in the spaces provided.

Physical Goals: **Nutritional/ Biochemical Goals** **Psychological Goals**

_________________ ______________________ ____________________
_________________ ______________________ ____________________
_________________ ______________________ ____________________

Hastings Chiropractic

Have you ever:
Bought bottled water: __ Yes __ No
Belonged to a health club: __ Yes __ No
Consumed vitamins or supplements __ Yes __ No
If there is a need for dietary changes would you like to know? __ Yes __ No
If there is a need for specific exercises would you like to know? __ Yes __ No
If there is a need for support in the psychological/mind/body/stress dimension of health would you like assistance? __ Yes __ No

I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date. I understand that I must give 24 hour cancellation notice of my appointments or else I may be charged for that time. I understand that I am responsible for payment at the time of my office visit. If I am a long distance client paying by check or money order, my payment must be received prior to my appointment.

Signature____Date:______________

Hastings Chiropractic