

Chiropractic Wellness Depot

Dr. Rachel Smith-Eschete
8210 Stephanie Dr., Suite B
Huntsville, AL 35802

PATIENT INFORMATION

Date: _____

Name: _____

(Last) (First) (MI)

Address: _____

City: _____ State: _____ Zip: _____

Phone: (Home) _____ (Work) _____

E-Mail Address: _____

Date of Birth: _____ Sex: M _____ F _____

(Mo/Day/Year)

Social Security Number: _____

Employer: _____

Occupation/Title: _____

Please tell us how you were referred to our office?

Personal Referral (Name): _____

Name: _____ Patient #: _____ Date: _____
 Age: _____ Male: _____ Female: _____ Single: _____ Married: _____ Divorced: _____ Widowed: _____
 # of Children: _____ Occupation: _____
 Reason for consulting our office: _____

YOUR HEALTH PROFILE

Why This Form Is Important

As a full spectrum Chiropractic office, we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical, and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

The Beginning Years (To Age 17)

Research is showing that many of the health challenges that occur later in life have their origins in the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

Your Childhood Years (Circle Y/N/Unsure)

		Comments
1. Did you have any childhood illnesses?	Y N Unsure	_____
2. Did you have any serious falls as a child?	Y N Unsure	_____
3. Did you play youth sports?	Y N Unsure	_____
4. Did you take/use any drugs?	Y N Unsure	_____
5. Did you have any surgery?	Y N Unsure	_____
6. Have you fallen/jumped from a height greater than 3 feet? (ie criib, bunk bed, trees)	Y N Unsure	_____
7. Were you involved in any car accidents as a child?	Y N Unsure	_____
8. Was there any prolonged use of medicine such as antibiotics or inhalers?	Y N Unsure	_____
9. Did you suffer any traumas (physical or emotional)?	Y N Unsure	_____
10. Were you vaccinated?	Y N Unsure	_____
11. As a child, were you under regular chiropractic care?	Y N Unsure	_____

Adults (Circle Y/N/Unsure)

		Comments
1. Do / did you smoke?	Y N Unsure	_____
2. Do / Did you drink alcohol?	Y N Unsure	_____
3. Have you had any surgery?	Y N Unsure	_____
4. Do / did you smoke?	Y N Unsure	_____
5. Do / did you play any adult sports?	Y N Unsure	_____
6. Do / did you participate in any extreme sports?	Y N Unsure	_____

7. On a scale of 1-10, describe your stress level:

(1 = none; 10 = extreme)

Occupational: _____

Personal: _____

8. On a scale of poor, good, or excellent, describe your:

Diet: _____ Exercise: _____ Sleep: _____ General Health: _____

Addressing The Issues That Brought You Into The Office

If you have no symptoms or complaints and are here for wellness services, please check here _____ "WISH TO HAVE CHIROPRACTIC WELLNESS SERVICES" and skip to "FAMILY HEALTH PROFILE".
Others need to briefly describe each chief area of complaint, including the effect it has had on your life.

If you are experiencing pain, is it:

___ Sharp ___ Dull ___ Comes and Goes ___ Travels ___ Constant

Since your problem started, it is.... ___ About the same ___ Getting Better ___ Getting Worse

What makes it worse: _____

Yes, it interferes with: ___ Work ___ Sleep ___ Walking ___ Sitting ___ Hobbies ___ Leisure

Other Doctors seen for this problem (please list):

Chiropractor: _____

Medical Doctor: _____

Other: _____

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

Headaches	Pins and needles in legs	Fainting	Back Pain
Ringing in ears	Loss of taste	Irritability	Cold hands
Fever	Problem urinating	Menstual irregularity	Neck pain
Pins and needles in arms	Loss of smell	Loss of balance	Dizziness
Buzzing in ears	Nervousness	Numbness in fingers	Numbness in toes
Stomach upset	Fatigue	Depression	Tension
Sleeping problems	Neck stiff	Cold feet	Tension
Constipation	Light bothers eyes	Cold sweats	Hot flashes
Heartburn	Mood swings	Menstrual pain	Ulcers

List any medication you are taking:

FAMILY HEALTH HISTORY:

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

Children: _____

Spouse: _____

Mother: _____

Father: _____

Sisters: _____

Brothers: _____

Others: _____

Have you ever:

Bought bottled water? Yes No

Belonged to a health club? Yes No

Consumed vitamins or supplements? Yes No

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

(signature)

(date)

CHIROPRACTIC WELLNESS DEPOT

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working toward the same objective.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

ADJUSTMENT: An adjustment is the specific application of force to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

HEALTH: A state of optimal physical, mental, and social well being, not merely the absence of disease or infirmity.

VERTEBRAL SUBLUXATION: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of nerve impulses, resulting in the lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment of those findings, we will recommend that you seek the services of a health care provider that specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom.

I, _____ have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

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INSURANCE VERIFICATION FORM

Before your first visit, use this to verify your insurance. Please fill out and bring with you on your first visit. This is an insurance verification form. Please contact your insurance company. Fill out this form as best you can. we will also call and double check your insurance for you. This process helps us get the information you need about the financial aspect of your chiropractic care. as soon as we get this form back, we will set up a time for your report of findings. Thank you for your cooperation in this matter.

Who Verified Insurance: _____

Title: _____

Is there coverage for chiropractic care? Yes No

Amount of Deductible: \$ _____ Individual \$ _____ Family \$ _____

Has Deductible been met? Yes No

If yes, how much has been met? _____

Coverage after deductible: _____

Is there a maximum yearly benefit? _____

Is there a maximum visit limit? _____

Are there any limitations? _____

Signature