The Recharging Station
FAMILY
CHIROPRACTIC

The Recharging Station

Dr. LuAnn Moratto
Sharon K. Cravens HHP

241 Greenwood Avenue
Bethel, CT 06801
therechargingstation.com

Adult
Wellness Profile

Practice Member Information ______________________ File ____________

Name: ____

Appointment Date M_______ D_________ 20 _______ Birth Date M _______ D _______ Y _______

Home Address: ____

City ______________________________ State ____________ Zip __________

Home Phone: ______________________________ May we leave a message? ◯ Yes ◯ No

Cell Phone: ______________________________ May we leave a message? ◯ Yes ◯ No

Work Phone: ______________________________ May we leave a message? ◯ Yes ◯ No

Email: ____

May we add you to our email newsletter and calendar of events? ◯ Yes ◯ No (Your email will not be shared)

Spouse's name? ____

Name(s) and age(s) of children: __________ __________ __________ __________

Occupation: ____

Do you primarily: ◯ Sit ◯ Stand ◯ Perform repetitive tasks

How did you hear about us? ____

Healthcare History

Have you had previous chiropractic care? ◯ No ◯ Yes

Who was your previous Chiropractor? ______________________________

Where? ______________________ When? ______________________

Were X-rays taken in the last 6 months? ◯ Yes ◯ No

What was the primary reason for consulting that office?

◯ Relief Care - Symptom relief of pain or discomfort

◯ Corrective Care - Correcting, relieving and stabilizing spinal, joint and postural issues

◯ Wellness Care - Maximizing the body's ability for optimal healing and function

Do you feel your previous chiropractic care was effective? ◯ No ◯ Yes

Please explain: ______________________________

Are you wearing: ◯ Heel Lifts ◯ Custom Orthotics

Family Doctor: ______________________________

Date and reason of last visit: ______________________________

May we contact your family doctor regarding your care at our office if necessary? ◯ No ◯ Yes

Naturopathic Doctor: ______________________________

Date and reason of last visit: ______________________________

Other Specialists and healthcare professionals:

Name: ______________________________

Professional Designation: ______________________________

Date and reason of last visit: ______________________________

Name: ______________________________

Professional Designation: ______________________________

Date and reason of last visit: ______________________________

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203-748-1941

Wellness Profile

Do you have a specific concern that brings you in?
☐ No, I'm interested in having my nervous system assessed to achieve optimal health and functioning.
☐ Yes:______________________________

If yes, please answer the following questions:
What is your primary area of complaint today? ______________________________
How long have you been aware of this? __________ days __________ weeks __________ months __________ years
Where else does this pain go in your body? ______________________________
How often do you experience this? ☐ daily ☐ weekly ☐ monthly ☐ comes and goes ☐ constantly
On a scale of 1 to 10 (10 being the worst), how does it feel when it's at its worst?__________
How would you describe the pain/discomfort?
☐ Dull ☐ Achy ☐ Throbbing ☐ Stabbing ☐ Tight/Stiff ☐ Burning ☐ Sharp ☐ Other __________
What makes it feel worse?______________________________
What makes it feel better?______________________________
Do you notice any other problems in your body when you get this pain/discomfort?__________
Do you feel your condition getting progressively worse? ☐ No ☐ Yes
Do you feel your condition can be healed? ☐ No ☐ Yes
What have you tried that ***has*** helped? ☐ Ice ☐ Heat ☐ Medication ☐ Massage ☐ Physical Therapy ☐ Chiropractic
☐ Other ______________________________
What have you tried that ***hasn't*** helped? ☐ Ice ☐ Heat ☐ Medication ☐ Massage ☐ Physical Therapy ☐ Chiropractic
☐ Other ______________________________

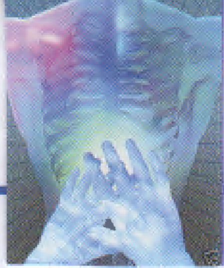
See additional ***Spinal Nerve Function Form*** to provide further detail on your *Wellness Profile* (**Page5**)

Lifestyle Information

The human body is designed to be healthy. The primary system in the body which coordinates health and function is the nervous system. Your nervous system is surrounded and protected by the bones of the spine, called vertebrae. Physical, emotional, and chemical stresses, common to our contemporary lifestyle, can result in misalignment to the spinal column as well as damage the delicate nervous system. The result is a condition called a *Vertebral Subluxation*. The remainder of the intake form addresses the possible factors which may contribute to vertebral subluxation in your spine which may be impeding your body's ability to heal.

Physical

Height __________ Weight __________
Are you happy with your current physical appearance and abilities? ☐ Yes ☐ No
Frequency of exercise/week: Cardio? . . . . . ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7
Weight bearing? . ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7
Do you stretch after exercise or after other activities of poor posture? ☐ Yes ☐ Sometimes ☐ No
Hours of sleep/night? ☐ >6 ☐ 7-9 ☐ 10+
Do you feel refreshed upon waking? ☐ Always ☐ Sometimes ☐ Rarely
Age of mattress? _____ Do you feel your mattress is appropriate for your sleeping style? ☐ No ☐ Yes
Which position do you sleep? ☐ Back ☐ Belly Side: ☐ Right ☐ Left ☐ Both
Number of hours spent commuting/week? ☐ 0-2 ☐ 3-5 ☐ 6-8 ☐ 9-11 ☐ 12+
Number of hours spent at a desk or computer/week? ☐ 0 ☐ 1-5 ☐ 6-10 ☐ 11-20 ☐ 21-40 ☐ 41+
Number of hours spent on smart device/tablet/week? ☐ 0 ☐ 1-5 ☐ 6-10 ☐ 11-20 ☐ 21-40 ☐ 41+
Do you perform any repetitive tasks at home or at work? ☐ No ☐ Yes
Have you ever been hospitalized or had surgery? ☐ No ☐ Yes If yes why and when?__________
____
Have you ever been in a motor vehicle accident (even if it was minor)? ☐ No ☐ Yes
If yes, what kind and when? ______________________________
Were you evaluated and treated after each accident? ☐ No ☐ Yes
Have you had any non-vehicle accidents or falls? ☐ No ☐ Yes ______________________________



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Early Years

To your knowledge, was your delivery difficult? ☐No ☐Yes
☐If yes: ☐Forceps ☐Vacuum ☐Caesarean ☐Breech ☐Other ____________
Were you breast fed? ☐No ☐Yes For how long? ____________
Did you experience emotional trauma as a child? ☐No ☐Yes ____________
Were you ever given antibiotics as a child? ☐No ☐Yes ____________
Did you ever have ear infections as a child? ☐No ☐Yes ____________
Any major childhood illness? ☐No ☐Yes ____________

Emotional

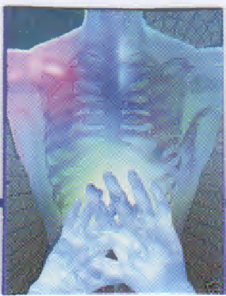
Rate your current level of ***personal stress*** in your life: . . . . ☐None ☐Low ☐Moderate ☐High
Rate your current level of ***relationship stress*** in your life: . . . . . . ☐None ☐Low ☐Moderate ☐High
Rate your current level of ***financial stress*** in your life: . . . . ☐None ☐Low ☐Moderate ☐High
Rate your current level of ***health stress*** in your life: . . . . ☐None ☐Low ☐Moderate ☐High
Rate your current level of ***family stress*** in your life: . . . . ☐None ☐Low ☐Moderate ☐High
Rate your current level of ***career stress*** in your life: . . . . ☐None ☐Low ☐Moderate ☐High
Do you feel you have a supportive network of friends and family? . . . ☐Yes ☐No
Do you feel you have healthy coping strategies for life stress? . . . . . ☐Yes ☐No

Chemical

Were you vaccinated as a child?. . . . . ☐No ☐Yes
Any adverse reactions to vaccines? . . . . ☐No ☐Yes ____________
Do you choose to have annual flu shots? . . . . ☐No ☐Yes
Do you take antibiotics?. . . . . ☐No ☐Yes, How often? ____________
How many glasses of water/day:. . . . . ☐0 ☐1-3 ☐4-6 ☐7-9 ☐10+
How many glasses of caffeinated beverages/day: . . . . ☐0 ☐1-3 ☐4-6 ☐7-9 ☐10+
How many glasses of cow's milk, juice and pop/day: . . . . ☐0 ☐1-3 ☐4-6 ☐7-9 ☐10+
Do you eat gluten?. . . . . ☐No ☐Yes ☐Trying to eliminate from diet
Do you eat dairy? . . . . ☐No ☐Yes ☐Trying to eliminate from diet
Do you eat refined sugars? (white sugar, white bread and pasta) . . . . ☐No ☐Yes ☐Trying to eliminate from diet
Do you eat boxed/frozen foods? . . . . ☐No ☐Yes ☐Trying to eliminate from diet
Do you choose organic foods? . . . . ☐No ☐Yes, which: ☐Veggies ☐Fruits ☐Meats ☐Grains ☐All
Do you eat any artificial sweeteners? (Splenda, Aspartame, Diet Soda, etc) ☐No ☐Yes
Any food/drink allergies, sensitivities, intolerances? . . . . ☐No ☐Yes ____________
Do you smoke? . . . . ☐No ☐Yes ☐I used to for__ years ☐I wish I didn't
Are you or have you been exposed to second hand smoke? . . . . ☐No ☐Yes
Do you drink alcohol? . . . . ☐No ☐Yes ☐0-6/week ☐6-12/week ☐12+/week
Do you take a probiotic daily?. . . . . ☐No ☐Yes, ______CFU's/day
Do you take vitamin D3 daily?. . . . . ☐No ☐Yes, ______IU's/day
Do you take Omega 3 Fish Oils daily?. . . . . ☐No ☐Yes, ______mg/day ☐Capsule ☐Liquid
Other supplements or homeopathics? ____________
Any other daily medication and their purpose? ____________

____

Do you have a plan in place with your medical doctor to wean yourself off of any long term medications? ☐No ☐Yes



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Family Health

At our clinic we are not only interested in your health and wellness, but also the health and wellness of the important people in your life. Please mention below any health conditions or concerns you may have about your:

Children: ______________________________

Spouse: ______________________________

Mother: ______________________________

Father: ______________________________

Brothers/Sisters: ______________________________

Are you seeking chiropractic care today for:

- ☐ Relief Care - Symptom relief of pain or discomfort
- ☐ Corrective Care - Correcting, relieving and stabilizing spinal, joint and postural issues
- ☐ Wellness Care - Maximizing the body's ability for optimal healing and function of the nervous system

Do you have other concerns we should know about? ______________________________

Goals & Consent

What is your primary goal for consulting our clinic? ______________________________

Our goals are to provide a detailed assessment of your current health status and provide to you the resources for a highly engaged and healthy body which is functioning at its absolute peak potential. Essential to this is a healthy nervous system functioning free from interference called subluxations. You've taken an important step for your health through a chiropractic evaluation!

Consent to Evaluation

I ______________________ __________ hereby grant permission to receive a chiropractic evaluation including history, spinal scan and examination. Any findings will be communicated before consenting to commencement of care, if appropriate.

______________________ ______________________

Consenting Adult's Signature Date

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Dr. LuAnn Moratto

Terms of Acceptance to Chiropractic and Connecticut Law

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

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it.

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 of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

In the State of Connecticut, General Statute chapter 327, section 20-24, Chiropractic is defined as such, "The practice of chiropractic means the practice of that branch of healing arts consisting of the science of adjustment, manipulation and treatment of the human body in which vertebral subluxations and other malpositioned articulations and structures that may interfere with the normal generation, transmission and expression of nerve impulse between the brain, organs and tissue cells of the body, which may cause of disease, are adjusted..."

I understand that Dr. Moratto does not offer to diagnose or treat any condition other than the vertebral subluxation. However, if during the course of your chiropractic spinal care, we encounter non-chiropractic or unusual findings, we will recommend that you seek the services of another health care provider.

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. Our only method is by specific adjusting to correct the vertebral subluxation.

I have read the above statements. I have also had an opportunity to ask questions about its content. All questions about the doctor's care pertaining to me in this office have been answered. The best health services are based on friendly, mutual understanding between provider and patient.

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

I therefore accept chiropractic care on this basis.

______________________________ ______________________________
(Signature) (Date)

Consent to evaluate and adjust a minor child:
I, ______________________ being the parent or legal guardian of ______________________ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

______________________________ ______________________________
(Signature) (Date)

METHOD OF PAYMENT

It is my pleasure to serve you. Please choose your most appropriate financial option.

___**Consultation**: I would like a free consultation to see if Chiropractic fits my needs and expectations. I would appreciate the opportunity to ask questions.

___**New Patient**: I am starting as a new practice member today. Initial Consultation - $375 Includes: Stress Response Evaluation, Assessment and First Chiropractic Adjustment.

___**Per Visit**: I will be paying at the time of each visit by cash or check. Each Visit: $65

___**Insurance**: PLEASE NOTE - WE ARE AN **OUT-OF-NETWORK OFFICE** (PLEASE MAKE SURE YOUR PLAN COVERS OUT-OF-NETWORK CHIROPRACTIC)

___I have insurance and will pay each time by cash or check. I would like a receipt upon each payment to send to my insurance company for reimbursement.

___I have insurance and would like you to bill my insurance company directly.

I authorize payment of benefits to be made directly to Dr. Moratto. I permit a copy of this authorization to be used in place of the original. I authorize any holder of medical or other information about me to be released to my doctor, Health Insurance Carrier or their intermediaries, any information necessary for my medical care or to process this related health insurance claim.

I understand and agree that regardless of my chosen method of payment, I am ultimately responsible for the balance due on my account and charges for services rendered. All fees not paid by my insurance are to be paid fully by me. I will be responsible for all and any expenses incurred in collecting my account. I have read all the information on this sheet. I certify this information is truthful and correct to the best of my knowledge. I do not hold Dr. Moratto or her staff responsible for it's accuracy. I will notify this office of any changes in the above information and personal information such as address, phone number, insurance information and medical status.

Signature:___________________________________ Date:__________

Printed Name:________________________________

Dr. LuAnn Moratto, 203-788-0935 / 241 Greenwood Ave, Bethel 06801 / 1065 Waterway Lane, Myrtle Beach, SC 29572