

# New Practice Member Entrance Form

Date \_\_\_\_\_ Who Can We Thank for Referring You \_\_\_\_\_

Name -First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ (Age ) SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Marital Status S M D W Spouses Name \_\_\_\_\_ Spouses DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Children (name-age) \_\_\_\_\_

E-mail Address (if you would like to receive our newsletter) \_\_\_\_\_

## About Your Health

The human body is designed to be healthy. Throughout life, events occur which damage your health expression. This case history will uncover the layers of damage that have occurred to your spinal column and nervous system. Please remember that it was a process becoming unhealthy, and it will be a process becoming healthy again.

When did you last see a Chiropractor? \_\_\_\_\_ Was it for  wellness or a  specific health issue  
Have you ever been taught about how to maintain a healthy spine and nervous system?  Yes  No  
If so, what were you taught? \_\_\_\_\_

Has any doctor ever placed you on a health maintenance plan?  Yes  No

List activities you do in your life that you feel help promote health? \_\_\_\_\_

## Everyday Events can interfere with Optimal Health & Wellness

The birth process can be very traumatic to the spinal column and nerve system and ultimately lead to a lack of proper function and healing. Please  all that apply to your birth process.

### 1. Birth Process

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Long delivery      | <input type="checkbox"/> Home birth     | <input type="checkbox"/> Forceps           | <input type="checkbox"/> Labor was induced     |
| <input type="checkbox"/> Difficult delivery | <input type="checkbox"/> Hospital birth | <input type="checkbox"/> Caesarean Section | <input type="checkbox"/> Drugs during delivery |
| <input type="checkbox"/> Vacuum Extraction  | <input type="checkbox"/> Other _____    |  |  |

Aging from toddler to teenage to adulthood also presents opportunities that compromise spinal column and nerve system function, thus leaving you at less than your optimal health.

### 2. Growth and development

- Slip/fall from bed/couch or down stairs  Falling when learning to walk  Spanking(how) \_\_\_\_\_  
 Any other traumas/accidents? What/When? \_\_\_\_\_  
 Sports \_\_\_\_\_  Hobbies \_\_\_\_\_

Our daily lives full of chemical, physical, & mental stresses that have a major influence on how healthy we can be. Please  all that apply to your current lifestyle.

### 3. Current Health Habits

- Did/do you smoke(amt/day) \_\_\_\_\_  Did/do you drink any alcohol \_\_\_\_\_  
 Have you been in any accidents (auto,home,work) \_\_\_\_\_  
 Rate your Diet (1-10) 10 being healthiest diet possible \_\_\_\_\_

- Hobbies/Sports injuries\_\_\_\_\_
- Sleeping habits ( \_\_side\_\_ stomach\_\_ back)                       Exercise regularly ( \_\_\_\_\_times per week)
- Occupational/work stress             Physical stress             Mental stress (deadlines,family,health)
- Surgery/Organs removed/replaced?\_\_\_\_\_
- Drugs?(prescription/over counter)\_\_\_\_\_
- Adverse side effects\_\_\_\_\_

**Symptoms and Ill Health (Present State of Ill Health)**

Finally, the years of continuing damage accumulate and show up as acute or chronic symptoms.

Present Complaint (be brief) \_\_\_\_\_

Date began\_\_\_\_\_ How did it begin\_\_\_\_\_

Have you had this problem before? Y N If Y when and what treatment did you seek?\_\_\_\_\_

Is the problem:  getting better  worse  staying the same    Is your problem:  constant  come and go

It's at its worst in the  morning  afternoon  evening

Is this condition interfering with Routine?\_\_\_\_\_ Work?\_\_\_\_\_ Sleep?\_\_\_\_\_ Quality of Life? \_\_\_\_\_

Hobbies?\_\_\_\_\_ (please circle)Gardening    sports    playing-lifting children/grandchildren    exercise    housework

What helps the problem? ICE/HEAT/REST/STRETCHING/EXERCISE/Medications/Other\_\_\_\_\_

What worsens the problem? SITTING/STANDING/BENDING/Medication side effects/Other\_\_\_\_\_

What are your expectations of us in reference to this problem?\_\_\_\_\_

How committed are you to restoring your overall health as well as your present problem? (rate 1-10 (10 highest))\_\_\_\_\_

Other indicators of ill health:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Headaches                | <input type="checkbox"/> Pins & Needles in Legs/Arms         | <input type="checkbox"/> Sleeping Problems                |
| <input type="checkbox"/> Neck Pain/Stiffness      | <input type="checkbox"/> Back Pain                           | <input type="checkbox"/> Dizziness/Loss of Balance        |
| <input type="checkbox"/> Numbness in Fingers/Toes | <input type="checkbox"/> Shortness of Breath/Chest Pains     | <input type="checkbox"/> Lights Bother Eyes               |
| <input type="checkbox"/> Cold Feet/Hands          | <input type="checkbox"/> Diarrhea/Constipation/Stomach Upset | <input type="checkbox"/> Tension/Nervousness/Irritability |
| <input type="checkbox"/> Fatigue                  | <input type="checkbox"/> Depression                          | <input type="checkbox"/> Ears Ring/Buzz/Pop               |

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that the Doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate care, in conflict with the Doctor's recommendations, any fees for professional services rendered to me will be due immediately and must be paid, even if insurance claims are in process. Any receipt of money's after the fact will be refunded directly to the patient.

I hereby authorize the Doctor to render care as he deems appropriate for specified spinal concerns. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the x-ray negatives will remain the property of this office. X-rays will be on file, where they may be seen at any time while I am patient of this office.

I, the undersigned, not only understand everything stated above but I also assign directly to Dr. Jason Yoder or Dr. Jud Heldreth & Palmetto Chiropractic Center, Inc. all insurance benefits payable for services rendered.

Practice Member Name(print)\_\_\_\_\_ Date\_\_\_\_\_

Practice Member Signature\_\_\_\_\_ Date\_\_\_\_\_

Parent/Guardian Signature if Practice Member is a minor\_\_\_\_\_ Date\_\_\_\_\_

## 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 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. This will prevent any confusion or disappointment.

**Adjustment:** An adjustment is the specific application of forces 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 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 mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition 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 for those findings, we will recommend that you seek the services of a health care provider who 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. Our only method is specific adjusting to correct vertebral subluxations.

I, \_\_\_\_\_ have read and fully understand the above statements.  
(print name)

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

\_\_\_\_\_  
(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.

### Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctors and their associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual period: \_\_\_\_\_

\_\_\_\_\_  
(signature)

\_\_\_\_\_  
(date)