

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_____

