

WELCOME

New Patient NET- Neuro Emotional Technique Intake

PATIENT INFORMATION			
Full Name		Date of Birth	Age
Address		City	State
Gender	Marital Status	Spouse's Name	Occupation
Cell Phone	Home Phone	Email Address	
In Case of Emergency, Contact:		Phone	Relationship
How did you hear about us?			
PATIENT CONDITION			
Reason for Visit:			
When did your symptoms appear?			
What was going on in your life when your symptoms first appeared?			
How often do you have symptoms?		Is this condition getting worse? ☐ Yes ☐ No ☐ Unsure	
Are you currently being treated for your symptoms, or have you received treatment in the past? If yes, what type of treatment have you received? Has it been helpful?			
Do you feel that stress affects you? ☐ Yes ☐ No ☐ Unsure			

Rate the severity of your stress on a scale from 1 (lowest) to 10 (highest) in the following areas:

Financial /10

Relationships/Family /10

Job/Career /10

Spiritual Health /10

Physical Health /10

Mental Health /10

In general, would you say your health is: ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Compared to one year ago, how would you rate your health in general now?

☐ Much better now than one year ago ☐ Somewhat better now than one year ago

☐ About the same ☐ Somewhat worse now than one year ago ☐ Much worse now than one year ago

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your stress? (Yes or No)

Cut down on the time you spent on work or other activities

☐ Yes ☐ No ☐ Unsure

Accomplished less than you would like

☐ Yes ☐ No ☐ Unsure

Didn't do work or other activities as carefully as usual

☐ Yes ☐ No ☐ Unsure

How much bodily pain have you had during the past 4 weeks?

☐ None ☐ Very Mild ☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe

During the past 4 weeks, how much did pain interfere with your normal work?

☐ All of the time ☐ Most of the time ☐ Some of the time ☐ A little of the time ☐ None of the time

During the past 4 weeks, how much of the time has your stress interfered with social activities?

☐ All of the time ☐ Most of the time ☐ Some of the time ☐ A little of the time ☐ None of the time

What would success look or feel like to you?

Any other details you would like to share?

Signature X

TERMS OF ACCEPTANCE

Health: A state of optimal physical, mental, and social well-being, not merely the absence of ailment.

Adjustment: An adjustment is a 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.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae 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 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 goal is to eliminate any major interference to the expression of the body's innate wisdom. Our method is by specific adjustments of the spine to correct vertebral subluxations.

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 and I therefore accept care on this basis.

Initial: _____

Notice of Privacy Practices:

I acknowledge that I have read and understand Mind Body Health & Chiropractic's "Notice of Privacy Practices" and that I am aware that a copy of the notice can be obtained from the doctor or his staff.

Initial: _____

Optional Disclosure Authorization:

I hereby request that the below listed person(s) be given permission for the following purposes on my behalf:

(check all that apply)

- ☐ Scheduling/changing/confirming appointments
- ☐ Bill payment/insurance
- ☐ Medical records/health information permission
- ☐ Other (specify) _____

Name of authorized person(s): _____

For Chiropractic Care X-ray Imaging:

Pregnancy Release (if applicable):

This certifies that to the best of my knowledge **I am not pregnant**, and the doctor and his associates have my permission to perform X-ray evaluation, if needed. I have been advised that X-ray can be hazardous to an unborn child.

Initial: _____

Consent to evaluate and adjust a minor child (if applicable):

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.

Initial: _____

Please sign and date below that you have read, understood, and agree to the above notices.

X _____
Signature

_____/_____/_____
Date