

# Entrance Form

**PRINT NEATLY!**

Today's Date: \_\_\_\_\_

Last Name: \_\_\_\_\_ Legal First Name: \_\_\_\_\_ Name you choose to be called: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, & Zip: \_\_\_\_\_

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

E-mail address: \_\_\_\_\_ Occupation: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Number of Children: \_\_\_\_\_

Names and Ages of People Living With You:  
////////////////////////////////////

How did you hear about Dr. Michael? / Who referred you?  
\_\_\_\_\_

Which of the following choices most accurately describes you?  
(Circle the ONE Best Answer) I am here mostly for my: A) Health, B) Relationship, C) Personal Life, D) Professional Life  
(Circle One) In being here, I am mostly: A) Motivated, B) Concerned, C) Excited, D) Skeptical  
(Circle One) Concerning my work here, I will be a: A) Great Partner, B) Challenge, C) Curious Observer, D) Other \_\_\_\_\_

What are some specific goals you have for being here today?  
\_\_\_\_\_

What you are currently taking? (Circle the titles below, list what you're taking, and describe why you're taking them.)  
Prescription Drugs      Non-Prescription Drugs      Herbs      Homeopathic Remedies      Supplements

Are you following a special diet? If yes, explain \_\_\_\_\_ Do you smoke? If yes, how much \_\_\_\_\_

Hours of sleep per night: \_\_\_\_\_ Describe your quality of sleep: (Excellent / Good / Average / Sporadic / Poor)

List any history of emotional trauma and provide dates:  
\_\_\_\_\_

List any history of significant physical trauma (falls, accidents, injuries, etc.) and provide dates:  
\_\_\_\_\_

List any history of hospitalizations or surgeries and provide dates:  
\_\_\_\_\_

Two-parts: 1) Underline what you have done in the past ... AND ... 2) Circle what you are still currently doing or receiving these days:  
Chiropractic    Coaching    Counseling    Exercise    Massage    Meditation    Physical Therapy    Yoga

What other strategies do you use for taking care of yourself (for your health, attitude, wellbeing, quality of life, personal growth, etc.)?  
\_\_\_\_\_

On a scale of 0-100, how would you grade your overall: Physical State? \_\_\_\_\_ Mental State? \_\_\_\_\_ Emotional State? \_\_\_\_\_

What do you do for enjoyment? \_\_\_\_\_ What inspires you? \_\_\_\_\_

What else would you like Dr. Michael to know about you, things that may help him better understand, serve, and support you?  
\_\_\_\_\_

## ***STATEMENT OF OBJECTIVE AND AGREEMENT:***

The purpose of this page is to clearly state the objectives of care. Initial each line to indicate your understanding and acceptance of the services you are receiving here and the obligations you have to yourself.

- \_\_\_\_\_ I understand that Dr. Michael A. Scimeca received his doctorate in chiropractic in 1993.
- \_\_\_\_\_ I understand that he is first and foremost an educator, helping me help myself in many areas relating to my wellbeing.
- \_\_\_\_\_ I understand that he uses Greaterness Coaching (GC), an approach he developed to help me better help myself.
- \_\_\_\_\_ I understand the purpose of GC is to help me take my life and my participation in my life to greater and higher levels.
- \_\_\_\_\_ I understand that dialoguing with him is for the purpose of arriving at a “mantra” (a focusing phrase) for helping me make continuous improvements in my life / for my greater wellbeing.
- \_\_\_\_\_ When working on my body, I understand that Dr. Michael first employs Catalyst, a system he developed in 1995.
- \_\_\_\_\_ I understand that Catalyst assesses and addresses the state and functionality of my neurology / neuroplasticity.
- \_\_\_\_\_ If, through his system of assessment, he determines I would benefit from a chiropractic adjustment, he practices Neuro-Spinal Integration (NSI), a system he developed and teaches at Life University to doctors of chiropractic and students.
- \_\_\_\_\_ Dr. Michael focuses on Successions, taking the subsequent steps necessary to thrive and succeed more efficiently.
- \_\_\_\_\_ Forward Healing involves the art of learning how to step well (better) into each new phase of life, emerging gracefully.
- \_\_\_\_\_ I approve the use of Greaterness Coaching, Successions, and Forward Healing to help me better live an inspired life.
- \_\_\_\_\_ I approve the use of Catalyst to help my body and me function more optimally / expansively.
- \_\_\_\_\_ When practicing as a chiropractor, Dr. Michael removes vertebral subluxations (misalignments / interference) of the spine to facilitate a greater life expression between brain cell and tissue cell.
- \_\_\_\_\_ I understand that the services I receive from Dr. Michael are NOT alternatives to receiving prompt medical attention.
- \_\_\_\_\_ I shall not confuse the services I receive from Dr. Michael with me fulfilling any personal responsibilities I have regarding me receiving expeditious medical care for any conditions I may knowingly or unknowingly have.
- \_\_\_\_\_ I understand that Dr. Michael’s approach is NOT to be in conflict or in competition with medical treatments and therapies.
- \_\_\_\_\_ Furthermore, I understand that Dr. Michael’s approach is NOT to be used in place of medical or other types of care.
- \_\_\_\_\_ I understand that Dr. Michael focuses on thriving, on me achieving my goals personally, professionally, or otherwise.
- \_\_\_\_\_ I understand Dr. Michael does NOT name or treat symptoms, conditions, diseases, or ailments of any kind.
- \_\_\_\_\_ I understand that Dr. Michael does NOT discourage me from seeking a diagnosis or treatment for any ailments, symptoms, conditions, or diseases I may be experiencing or expressing.
- \_\_\_\_\_ I understand that any suggestion or recommendation I receive from Dr. Michael is NOT “prescriptive advice.”
- \_\_\_\_\_ I understand that any suggestion or recommendation is NOT a replacement for professional counseling and/or therapy.
- \_\_\_\_\_ I understand that I should address any mental health concerns I may have with a licensed mental health professional.
- \_\_\_\_\_ I understand that my responsibility is to present questions or concerns I have regarding office policies and procedures.
- \_\_\_\_\_ I understand that payment is due in full at the time services are rendered unless prior arrangements have been made.
- \_\_\_\_\_ I understand that I can receive certain complimentary sessions by using a pre-payment method.
- \_\_\_\_\_ I understand that Dr. Michael has a refund policy for any pre-payment plan I may choose to use.
- \_\_\_\_\_ I understand there is a cancellation policy that requires at least a 24-hour notice not to be charged for that appointment.
- \_\_\_\_\_ I understand that additional information about policies, procedures, and services is available at [www.scimeca.com](http://www.scimeca.com).
- \_\_\_\_\_ I accept full responsibility for decisions I make, including whether or not to receive Dr. Michael’s services and support.
- \_\_\_\_\_ I do hereby for myself, my heirs, my executors, and my administrators, waive, release, and forever discharge any and all rights and claims for damages which I have or which may hereafter accrue to me against Dr. Michael A. Scimeca for any and all demands, liabilities, rights, or causes of action arising out of or in connection with me choosing to use his services.
- \_\_\_\_\_ I agree to defend, indemnify, and hold Dr. Michael A. Scimeca harmless from and against any claims, actions or demands, liabilities and settlements including without limitation, reasonable legal and accounting fees, resulting from, or alleged to result from, my violation of the terms and conditions of this Agreement.
- \_\_\_\_\_ My signature certifies that I have read and agree to these objectives in their entirety.
- \_\_\_\_\_ I am signing this agreement voluntarily and accept all of the terms above.

### **FOR THE PARENT OR GUARDIAN OF A MINOR CHILD FOR WHICH THIS FORM IS BEING COMPLETED:**

- \_\_\_\_\_ I, the undersigned, state that I am the legal parent or guardian of the minor child listed on this form.
- \_\_\_\_\_ I fully understand Dr. Michael’s services and how they may be applied for my minor child.
- \_\_\_\_\_ I give consent for my minor child listed on this form to receive the specialized services and support of Dr. Michael.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*“Any step in the right direction, no matter how great or how small, is a step in the right direction.”*