David Yoder
Wellness Center
Let your body heal you.

New Patient Intake Form

Personal Information

Patient Name:_____ Date: _____

Address: _____ City:_____ State: ____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ SSN: _____-____-_____

Date of Birth: ____-____-_____ Email Address: _____

Sex: ❑M ❑F Married ❑ Single ❑ Spouse Name: _____

Children's Names and Ages: _____

Occupation:_____Your Employer: _____

Hobbies:_____

Referred by: _____

Accidental injury? ___Yes ___No If yes, please complete the following

Date of Accident: _____-_____-_____

Accident type: Work Auto School Home Other:_____

Reason for Consulting Our Office

❑ I have a specific problem and am looking for temporary pain relief.

❑ I am interested in lasting correction with my specific problem and learning strategies to help.

❑ I am interested in strategies to improve my overall health and to keep me well.

❑ I would like the Doctor to determine the type of care best for me.

What is your major complaint(s)? _____
_____

How long have you had this condition? _____

How did this condition develop? (What caused it? How did it start?) _____
_____

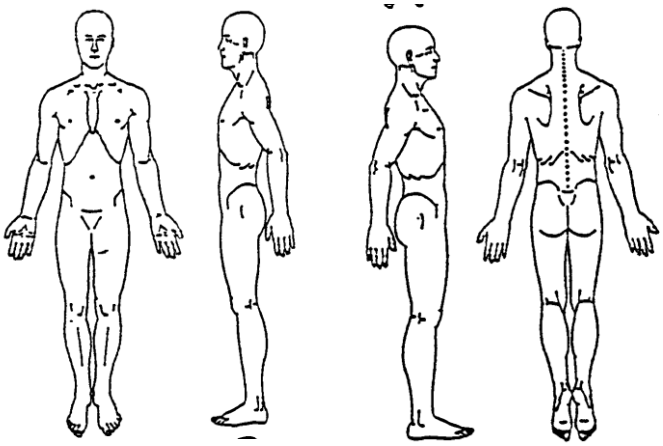
What activities aggravate your condition? _____

What makes it better? _____

Is the condition getting better, worse or staying the same? _____

My condition is interfering with ❑ Work ❑ Sleep ❑ Recreation ❑ Daily Routine
Explain: _____

Please mark the exact location of your pain on the diagram below.



Rate the severity of your pain from
1 to 10 (1=least, 10=greatest) _____

Type of Pain:
❑ Sharp ❑ Throbbing
❑ Numbness ❑ Shooting
❑ Burning ❑ Cramps
❑ Stiffness ❑ Swelling
❑ Dull ❑ Tingling
❑ Aching ❑ Other _____

Health Information

Have you received wellness care or chiropractic care before? ❑ Yes ❑ No
If so, what was the reason?_____
Name:_____ Date Consulted:_____

Have you had previous healthcare for you present problem? ❑ Yes ❑ No
If so, where?_____ When?_____

List any surgical operations: _____

List any drugs (prescription, over the counter) and/or vitamins, natural supplements that you are presently taking:_____
_____

Are you affected by any of the following:
Please check: **O** = Occasionally **F** = Frequently **C** = Constantly

	O	F	C		O	F	C		O	F	C
Asthma	☐	☐	☐	Headaches	☐	☐	☐	Heart burn	☐	☐	☐
Backache	☐	☐	☐	Sinus trouble	☐	☐	☐	Migraines	☐	☐	☐
Neck Pain	☐	☐	☐	Digestive upset	☐	☐	☐	High Blood Pressure	☐	☐	☐
Allergy	☐	☐	☐	Constipation	☐	☐	☐	**Females only:**			
Earache	☐	☐	☐	Dizziness	☐	☐	☐	Painful menstruation	☐	☐	☐
Sore throat	☐	☐	☐	Shoulder pain	☐	☐	☐	PMS	☐	☐	☐
Foot Pain	☐	☐	☐	Leg pain	☐	☐	☐	Hot flashes	☐	☐	☐

I, the undersigned, having been explained the risks of treatment, do hereby request and consent to the performance of wellness care and related procedures upon the above-named patient (my dependent or myself). I wish to rely on the doctor or practitioner to exercise judgment for my best interest during the course of treatment. I will inform the doctor or practitioner who is treating me of any sensitive areas or adverse conditions I may have had prior to, during, or after treatment. I intend this consent to cover the entire course of treatment.

Signed: _____Date:_____

Chemical Balance Form

The purpose of this NUTRITIONAL QUESTIONNAIRE is to help determine your alkaline reserve status (your pH), because healing happens within the body in a certain chemical range. Anything outside of that range can slow down or stop the healing process.

How quickly you get well is determined by the chemical balance in your body. Chemical balance determined, in large, by what you eat. Please indicate amounts and frequencies you partake in the following:

YOU MUST BE BRUTALLY HONEST!

Amount of:	Per Day	Per Week
1. Coffee (caffeinated/decaffeinated)	_____cups	_____cups
2. Tea (herbal & regular)	_____cups	_____cups
3. Sugar, sweets, desserts, candy, and artificial sweeteners	_____times	_____times
4. Salt, salty snacks, chips, etc.	_____servings	_____servings
5. Do you add salt to food at meal time?	☐ Yes ☐ No ☐Occasionally	
6. Red meat (beef, pork, bacon, ham, etc.)	_____times	_____times
7. Chicken/Fish	_____times	_____times
8. Dairy (milk, cheese, ice cream, etc.)	_____times	_____times
9. Water	_____glasses	_____glasses
10. Fresh fruits	_____pieces	_____pieces
11. Fresh vegetables (non-canned)	_____servings	_____servings
12. Alcoholic beverages	_____servings	_____servings
13. Soft drinks (caffeinated/decaffeinated)	_____servings	_____servings
14. Smoking	_____packs	_____packs
15. Bowel movements	____/day	_____/wk
16. White flour/Gluten	_____servings	_____servings

Wellness Care Form

Bio-Energetic Synchronization Technique is ultimately about wellness care. Granted, many of us will have symptoms or issues that need to be dealt with immediately, but eventually, as those become resolved, we have the ability to create the life and health picture of our dreams.

In order for our office to assist you in achieving your wellness status, help us define what that would look like for you. List 3 goals you would love to achieve regarding your perfect health and your ideal life. (Use your imagination and assume that anything would be possible for you.)

1._____

2._____

3._____

On a scale of 1 -10, with 1 being "not much" and 10 being "almost anything" demonstrate what you would be willing to change, let go of, shift, start, or stop in order to accomplish these goals.

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1 2 3 4 5 6 7 8 9 10

- Does it feel possible to personally achieve these goals?
  ❑ Yes ❑No

- Would you be willing to investigate any *subconscious* interference that may be getting in your way? (You won't need to reveal any personal information to in order to do so.)
  ❑ Yes ❑No

- Have you ever had someone demonstrate (via muscle testing) how your *subconscious* beliefs can sabotage your ability to obtain your goals? The Law of Attraction operates through your *subconscious* mind. What your *subconscious* believes is what will manifest in your life.
  ❑ Yes ❑No

- Did you know there is a procedure you can easily learn that would enable you (working with a partner) to remove the *subconscious* interference that stops you from achieving your goals?
  ❑ Yes ❑No

- Would you like to learn how? It's called BEST RELEASE.
  ❑ Yes ❑No

"With your commitment and this technique, we can make a difference."