Welcome to Living Well

PLEASE PRINT NEATLY! Today's Date:

Last Name: First Name: Name you prefer to be called:

Address: City, State, & Zip:

Home Phone: Work Phone: Cell 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 and Living Well? (Who referred you?)

Which of the following choices most accurately describes you today?
(Circle One Only) Concerning my health, I am looking to: A) Regain it, B) Maintain it, C) Improve it, D) Neither A, B, or C
(Circle One Only) Concerning my quality of life, I looking to: A) Regain it, B) Maintain it, C) Improve it, D) Neither A, B, or C

What are some of your specific goals that motivated you to be here today?

Circle the titles below of what you are currently taking: (Write the names and explain why)
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

Do you drink alcohol? If yes, how much Do you drink coffee or tea? If yes, how much

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

List any history of significant emotional trauma (provide dates):

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

List any history of chemical trauma (exposure to toxic substances) (and include any known food allergies and hypersensitivities):

List any history of hospitalizations or surgeries (provide dates):

1. Underline ALL below that you have done in the past: AND 2. *Circle* ALL below that you are currently doing:
Chiropractic Catalyst Coaching Counseling Exercise Massage Meditation Physical Therapy Yoga

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

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

What else should Dr. Michael know? (include pertinent information to help him better understand and serve you.)

STATEMENT OF OBJECTIVE / AGREEMENT:

The purpose of this side of the form is to clearly state the objectives of the services provided here. Initial each statement in the space provided to the left to indicate your understanding of these services and the obligations you have to yourself.

_____ Dr. Michael A. Scimeca, a licensed chiropractor, provides a unique service that he has personally developed for his clients.
_____ He calls his systematic approach "The Thrive Personal Development System."
_____ As a chiropractor, Dr. Michael removes vertebral subluxations (misalignments/interference) to facilitate a greater life expression between brain cell and tissue cell.
_____ Dr. Michael incorporates a combination of personalized tools in his practice to help his clients meet their specific goals.
_____ He practices life coaching using his own psycho-technology (Dynamic Cognitive Programming), a protocol that involves conversations between him and his clients for the purpose of clarifying a supportive (solution-minded) point of focus.
_____ His practices life coaching to help his clients: 1) focus on specific self-care goals, 2) discover their own recipes for success, and 3) be successful in meeting their own specific developmental needs.
_____ I, the undersigned, approve the use of Dynamic Cognitive Programming (dialogue/education) to help me better help myself.
_____ Dr. Michael also practices Catalyst; a gentle hands-on approach that physically contacts the body to facilitate positive changes through "neurological nutrition," the fact that the body is receptive-based and adapts well to specific stimuli.
_____ I approve the use of Catalyst to help my body (and me) function more peacefully, meaning with greater ease and flow.
_____ I understand that the services I receive here are NOT alternatives to receiving medical attention.
_____ I shall not confuse the services I receive from Dr. Michael with me fulfilling my personal responsibilities I have in receiving medical care expeditiously for any condition(s) I may knowingly and/or unknowingly have.
_____ I understand that Dr. Michael's Thrive Personal Development System is a separate educational entity, entirely different from and NOT in competition with conventional medical treatments and alternative therapies.
_____ Furthermore, Dr. Michael's unique approach is NOT to be used in place of medical care.
_____ I understand that Dr. Michael is first and foremost an educator who uses his own time-tested, personally developed system to teach me how I can help myself achieve my goals, whether they be personal, professional, health-related, or otherwise.
_____ I understand Dr. Michael does NOT name or treat symptoms, conditions, diseases, or ailments of any kind.
_____ I understand that Dr. Michael's objective is to help me achieve greater levels of success independent of any physical symptoms, conditions, diseases, or ailments I may be experiencing and/or expressing by helping me and my body thrive.
_____ I understand that Dr. Michael supports "Forward Healing," the art and practice of stepping well into each new phase of life.
_____ I understand that Dr. Michael does NOT discourage me from seeking a diagnosis and/or treatment for any symptom(s), condition(s), ailment(s), or disease(s) I may be experiencing and/or expressing.
_____ I understand that as it relates to this office, I am 100% responsible for receiving expeditious diagnosis and treatment for any known or unknown medical condition(s) I may be expressing.
_____ I further understand that any health concerns I may have should be brought to the attention of a properly trained, licensed healthcare professional who is actively practicing the comprehensive science of diagnosis and treatment.
_____ Dr. Michael has great respect for the comprehensive science and art of diagnosis and treatment and, therefore, will NOT use his limited knowledge and resources in those areas to even attempt to arrive at a diagnosis.
_____ I understand that any suggestions or recommendations I receive from Dr. Michael is neither prescriptive advice nor 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 additional information about the services Dr. Michael provides is available at www.scimeca.com.
_____ My responsibility is to present immediately any questions or concerns I have regarding office policies and procedures.
_____ I understand Dr. Michael cannot be held responsible or liable in any way for decisions I make after receiving his services.
_____ 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 use of Dr. Michael's services certifies that I have read and agree to this Statement of Objective/Agreement entirely.
_____ I am signing this Statement of Objective/Agreement voluntarily and not under duress of any kind.
_____ My signature below indicates my complete understanding and acceptance of all the above.
_____ I understand that payment is due in full at the time services are rendered unless prior arrangements have been made.

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 professional objectives and how they apply to my minor child.
_____ I give consent for my minor child listed on this form to receive the specialized services of Dr. Michael.

Signature: _____ Date: _____