

# Neuro-Spinal Integration (NSI) – Entrance Form

**PLEASE PRINT NEATLY!**

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

Last Name: \_\_\_\_\_ First Name (what 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: \_\_\_\_\_ # of Children: \_\_\_\_\_

Names with Ages of People Living With You: \_\_\_\_\_



How did you hear about me (or who referred you)? \_\_\_\_\_

What is your reason for seeking my services at this time? \_\_\_\_\_

Circle and explain if you are currently taking any of the following:  
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 (give dates): \_\_\_\_\_

List any history of significant falls, accidents, or injuries (give dates): \_\_\_\_\_

List any history of hospitalizations or surgeries (give dates): \_\_\_\_\_

(Read this carefully) Underline ALL you have done in the past, AND completely *Circle* ALL you are currently doing:  
Chiropractic, Counseling, Exercise, Massage, Meditation, Physical Therapy, Yoga

How would you grade your overall: Physical state? \_\_\_\_\_ Mental state? \_\_\_\_\_ Emotional state? \_\_\_\_\_

What are your current wellness objectives? \_\_\_\_\_

What would you like to achieve from receiving care in this office? \_\_\_\_\_

Please include other information you feel is pertinent that may help me better understand and serve you: \_\_\_\_\_

What do you most enjoy doing in your spare time? \_\_\_\_\_

(continue on the other side)

**WELLNESS PARTNERSHIP / STATEMENT OF OBJECTIVE:**

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

- \_\_\_\_\_ I, the undersigned, understand that the chiropractor in this office focuses on wellness exclusively.
- \_\_\_\_\_ I understand chiropractic is a science which concerns itself with the relationship between structure, primarily the spine, and function, primarily the nervous system, of the human body.
- \_\_\_\_\_ I understand the chiropractor from whom you are seeking care practices Neuro-Spinal Integration (NSI), a gentle system of adjustment that uses the integrity of the nervous system to support a greater degree of living well—of moving through life with more peace, grace, and ease.
- \_\_\_\_\_ I understand NSI is a wellness partnership between the chiropractor and myself in helping me achieve a greater degree of life enjoyment.
- \_\_\_\_\_ I understand this chiropractor does NOT name or treat symptoms, conditions, or ailments of any kind.
- \_\_\_\_\_ I understand the objective of NSI is to help me achieve greater levels of well-being independent of any physical symptom(s), condition(s), or ailment(s) I may be experiencing.
- \_\_\_\_\_ I understand the people affiliated with NSI do NOT discourage me from seeking a diagnosis and/or treatment for any symptom(s), condition(s), or ailment(s) I may be experiencing.
- \_\_\_\_\_ I fully understand that care in this office is NOT a treatment of any kind.
- \_\_\_\_\_ I understand I am fully responsible for my receiving proper diagnosis and treatment expeditiously for any known or unknown medical condition(s) I may be expressing.
- \_\_\_\_\_ I shall not confuse the care I receive in this office with fulfilling any responsibilities I have toward receiving conventional care expeditiously for any condition(s) I may have.
- \_\_\_\_\_ I understand any health concern(s) I may have should be brought to the attention of a licensed healthcare professional properly trained in and actively practicing the science and art of diagnosis and treatment.
- \_\_\_\_\_ I understand NSI is a system of practicing the art of living well, not the art of diagnosis and treatment.
- \_\_\_\_\_ I understand any suggestion or recommendation I receive in this office is neither prescriptive advice nor a replacement for professional counseling or therapy.
- \_\_\_\_\_ I understand I should address any mental health concern(s) I may have with a licensed mental health professional.
- \_\_\_\_\_ I understand additional information about NSI is available online at [www.NSIchiropractic.com](http://www.NSIchiropractic.com).
- \_\_\_\_\_ I understand my responsibility is to present, as soon as possible, any question(s) or concern(s) I may have regarding office policies, procedures, and/or objectives.
- \_\_\_\_\_ I understand this office uses an outcome-assessment survey at different intervals to monitor my subjective quality of life improvements.

**Initial the following statements to approve the use of Neuro-Spinal Integration (NSI):**

- \_\_\_\_\_ I, the undersigned, approve the use of NSI knowing it addresses only the wellness branch of chiropractic for the purpose of helping me improve and enjoy my state of well-being.

**For the parent or guardian of a minor child:**

- \_\_\_\_\_ I, the undersigned, state that I am the legal parent or guardian of the minor child listed on this form.
- \_\_\_\_\_ I fully understand the objectives of this office and how they apply to my minor child.
- \_\_\_\_\_ I give consent for my minor child listed on this form to receive NSI in this office.

*My signature below indicates my understanding and acceptance of all the above. I also understand that payment is due in full at the time services are rendered – unless prior arrangements have been made.*

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

**THANK YOU FOR ALLOWING ME THE OPPORTUNITY TO HELP YOU HELP YOURSELF**