BODY RIGHT CHIROPRACTIC S.C.

NEW PATIENT INFORMATION FORM

PLEASE PRINT CLEARLY:

Name_____Birthdate _____

Address_____City_____Zip_____

SSN_____ Marital Status S M W D Gender M or F

Phone_____Cell_____e-mail_____

Employer_____Occupation_____Work Phone_____

Would you like to receive text or e-mail reminders? Y or N Cell Provider_____

Spouse's Name_____Phone_____Employer_____

Have you been adjusted before? Yes or No Is pain work or auto accident related? (Circle)

Mark an "X" on the picture to show the areas you are having pain or discomfort

When did symptoms start?_____

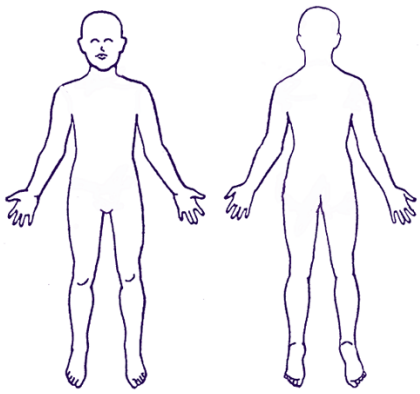
How did they occur?_____

Rate your pain on a scale of 0 to 10 _____

Do you have any current X-rays? Yes or No

Are you pregnant? Yes or No

Seeking treatment with any other provider for this issue? Yes or No



Type of pain (please circle): Sharp Dull Throbbing Numb Achy Shooting Other _____

Is your pain getting worse, better, or staying the same? (Circle) Is the pain constant? Y or N

What makes the pain better? _____What makes it worse? _____

Circle any of the following that are painful: Sitting Standing Walking Bending Sleeping Lifting

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List past surgeries and accidents/injuries:_____

_____

Current medications?_____

Allergies?_____

Please list any major illnesses or current condition (HBP, diabetes, asthma, heart, stroke, etc.)

_____

List skeletal injuries/conditions (broken bones, arthritis, degeneration): _____

_____

Family health history: Heart/Cancer/Diabetes/other:_____

Do you smoke (Y or N), drink caffeine (Y or N) or consume alcohol (Y or N)?

Work Habits (Circle): Mostly Lifting Mostly Standing Mostly Walking Mostly Sitting

Any additional information you feel is relevant to your care :

_____

_____

I CERTIFY THAT I AM THE PATIENT OR LEGAL GUARDIAN LISTED ABOVE. I HAVE READ/UNDERSTAND THE INCLUDED INFORMATION AND CERTIFY IT TO BE TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I CONSENT TO THE COLLECTION AND USE OF THE ABOVE INFORMATION TO THIS OFFICE OF CHIROPRACTIC. I AUTHORIZE THIS OFFICE AND ITS STAFF TO EXAMINE AND TREAT MY CONDITION AS THE DOCTOR(S) SEE FIT. I, HEREBY, AUTHORIZE THE DOCTOR(S) TO RELEASE ALL INFORMATION NECESSARY TO ANY INSURANCE COMPANY, ATTORNEY OR ADJUSTER FOR THE PURPOSE OF CLAIM REIMBURSEMENT OF CHARGES INCURRED BY ME. I GRANT THE USE OF MY SIGNED STATEMENT OF AUTHORIZATION FOR REQUIRED INSURANCE SUBMISSIONS. I UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME WILL BE CHARGED TO ME, AND I AM RESPONSIBLE FOR TIMELY PAYMENT OF SUCH SERVICES. I UNDERSTAND AND AGREE THAT HEALTH/ ACCIDENT INSURANCE POLICIES ARE ARRANGEMENTS BETWEEN AN INSURANCE CARRIER AND MYSELF. I UNDERSTAND THAT THE FEES FOR PROFESSIONAL SERVICES WILL BECOME IMMEDIATELY DUE UPON SUSPENSION OR TERMINATION OF MY CARE OR TREATMENT.

PRINTED NAME_____

SIGNATURE_____DATE_____

BODY RIGHT CHIROPRACTIC S.C.

333 North 8th Street. Medford, WI 54451

Notice of Privacy Practices

I acknowledge that I have received the Notice of Privacy Practices and have completed the "Acknowledgement of Receipt of the Notice of Privacy Practices."

Authorization for Use & Disclosure of Protected Health Information (PHI) and Wisconsin Consent

I understand that by signing below I authorize the Use and Disclosure of my Protected Health Information (PHI) described herein and in the Notice of Privacy Practices that has been provided to me. I also acknowledge that Body Right Chiropractic "BRC" has reserved the right to make changes to the privacy practices as necessary. If BRC makes any changes, a revised Notice of Privacy Practices will be provided to me. I understand those changes will apply to any of my PHI that Body Right Chiropractic maintains.

Check any additional Use and Disclosure authorizations that may apply:

☐ I consent to disclosure of my patient health care records for disaster relief purposes as permitted by law.

☐ I consent to use and disclosure of my patient health care records to the following person(s), including those involved in my care or payment for that care. [Specify person(s) below]:

_____ _____
(Person Name) (Relationship

_____
(Address)

_____ _____
(Person Name) (Relationship)

_____
(Address)

_____ _____
Signature Date

BODY RIGHT CHIROPRACTIC S.C.

333 N 8th Street • Medford, WI 54451
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INFORMED CONSENT TO CHIROPRACTIC CARE

In accordance with Wisconsin Statute § 446.08 and Wisconsin Administrative Code Chapter Chir 13, the State of Wisconsin requires chiropractors to inform patients about the availability of reasonable alternate modes of treatment, along with the benefits and risks associated with these options. This disclosure follows the "reasonable chiropractor standard," which requires disclosure only of information that a reasonable chiropractor would know and disclose under the circumstances. Wisconsin administrative rules explicitly note that a chiropractor's duty to inform does not require disclosure of extremely remote possibilities that might falsely or detrimentally alarm the patient.

Please read this document carefully before signing. This form is intended to cover your entire course of treatment for your current condition and any future conditions for which you seek treatment at this clinic.

1. The Nature of Chiropractic Manipulative Therapy (CMT)

Chiropractic manipulative therapy—often called an adjustment—involves the application of a precise, controlled force in a specific direction to a joint that is hypomobile or not moving properly. The doctor will use their hands or a specialized mechanical device to perform this movement. During the adjustment, you may feel joint movement and hear or feel a "pop" or "click" sound, which is simply the release of gas bubbles from within the joint fluid.

2. The Purpose and Material Risks of CMT

The primary goal of CMT is to reduce joint dysfunction, improve overall spinal alignment, restore motion, and alleviate nerve interference or pain. While chiropractic care is widely recognized as one of the safest, non-invasive therapies for neuromusculoskeletal conditions, you must be informed of potential material risks under Wisconsin law:

- **Common Risks:** Temporary stiffness, localized muscle soreness, or minor discomfort following treatment.
- **Rare Risks:** Muscle strains, ligament sprains, or aggravated disc herniation/protrusion.
- **Extremely Rare Risks:** Bone fractures (primarily in patients with underlying bone density issues like severe osteoporosis).

3. The Purpose and Risks of Ancillary Physical Therapies

To complement your adjustments and accelerate healing, our clinic utilizes therapeutic modalities including Electrical Muscle Stimulation (EMS) and Therapeutic Ultrasound.

- **Electrical Muscle Stimulation (EMS):** Uses light electrical currents to reduce muscle spasms, alleviate pain, and decrease inflammation. Minor risks include temporary skin irritation or mild redness under the electrode pads.
- **Therapeutic Ultrasound:** Utilizes sound waves to generate deep heat within soft tissues, promoting blood flow and tissue relaxation. Minor risks include rare, temporary heating discomfort or mild skin sensitivity.

4. The Purpose and Risks of X-Ray Examination

To properly assess your skeletal structure, identify underlying pathology, and safely direct your care, the doctor may recommend clinical X-rays.

- **Benefits:** Provides a clear diagnostic look at the spine, joints, and bone structure to ensure CMT and therapies are safe and tailored to your body.
- **Risks:** X-rays expose the body to a minimal dose of ionizing radiation. Our facility utilizes advanced, modern safety protocols to keep exposure as low as reasonably achievable.
- **Females Only: Radiation can be harmful to an unborn fetus. You must notify the doctor or clinical staff immediately if there is any possibility that you are pregnant.**

5. Reasonable Alternate Modes of Treatment

You have the right to choose alternative approaches to manage your condition. Depending on your diagnosis, reasonable alternatives may include:

- Over-the-counter or prescription medications (such as anti-inflammatories, muscle relaxers, or pain relievers) managed by a medical physician.
- Physical therapy or targeted rehabilitation exercises.
- Medical specialist consultations, injections, or surgical interventions.
- Remaining untreated. If you choose to forgo treatment, you accept the risk that your condition may remain unchanged, worsen, or lead to progressive joint degeneration and chronic pain.

Patient Acknowledgement and Consent

By signing below, I acknowledge that I have read (or have read to me) this informed consent document. I understand the nature of chiropractic manipulative therapy, ancillary physical therapies (EMS and Ultrasound), and diagnostic X-rays, as well as the potential risks, benefits, and reasonable alternatives.

I have had the opportunity to ask questions regarding this information, and all of my questions have been answered to my satisfaction. I intend this consent form to apply to all treatments and diagnostic procedures rendered now and in the future under the direction of the chiropractors practicing at this facility.

Patient Name (Printed): _____

Patient Signature (or Parent/Guardian): _____

Date of Signature: _____

Doctor / Witness Signature: _____

Date of Signature: _____

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