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?_____

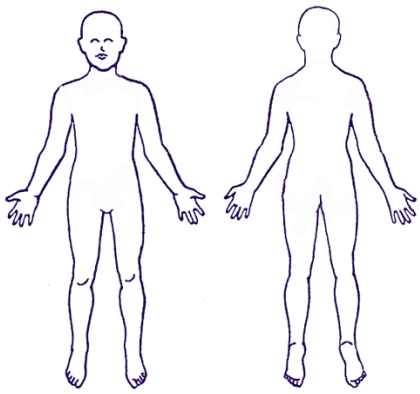
How did they occur?_____

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_____

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333 North 8th Street. Medford, WI 54451