



Work Hard. Play Hard. We Have Your Back!

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Patient Information:

Thank you for choosing our practice! Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We are happy to help.

(Please print)

Name: _____ Social Security #: _____ Date: _____
(First MI Last)

Address: _____ City: _____ State: _____
ZIP _____

Sex: Female Male Birthday: _____ Email: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
How do you prefer to be contacted? Phone Cell Email No Preference

Patient Status

Married Widowed Single Minor Separated Divorced Partnered

Patient Employer/School: _____

Occupation: _____

Spouse/Parent Name: _____ Employer: _____

Phone: _____

Person to contact in case of emergency: _____ Phone: _____

Whom may we thank for referring you to us? _____

Responsible Party:

Self/Same as above (Skip following if same as above) Other (Please complete the following if other)

Name of person responsible for this account: _____

Insurance Information:

Primary insurance:

Do you have an insurance card? Yes No Office Use Only: (Copy of Card on file)

Secondary Insurance: Yes No Office Use Only: (Copy of Card on file)

Financial Responsibility

By signing this statement I agree that I have reviewed Bear River Chiropractic's Financial Policy and agree to the terms listed including payment at time of service of applicable charges, deductible payments, copayments, or fee for services not otherwise prearranged.

Authorization to Release Medical Information

I authorize Bear River Chiropractic to release/request medical information on my behalf to/from any entity to assist in my medical care per my request. This assignment will remain in effect until revoked in writing.

Private Health Information

My signature below acknowledges that I was provided the opportunity to receive/review a copy of Bear River Chiropractic's Privacy Policy Notice.

Assignment of Insurance Benifits

I directly assign my insurance benefits to the billing physician otherwise payable to me for services rendered:

Consent to Treat

I have read and understand the risks regarding treatment side-effects. I also understand that there is no guarantee or warranty for a specific cure or result. I give my consent for treatment.

Patient signature: _____ Date: _____



Symptoms:

What is hurting you today? _____

First noticed: _____ Have you ever had this problem before & when? _____

Is this condition getting Progressively worse over time Constantly the same A little better over time

Any activity difficult for you to perform? Sitting Standing Walking Exercising Bending
 Laying down Breathing Other: _____

Type of Pain (mark all that apply): Sharp Dull Throbbing Aching Shooting Burning
 Tingling Cramps Stiffness Swelling Other: _____

Are you experiencing Numbness, tingling, weakness, or clumsiness of the arms/hand or legs/feet Yes

Rate the severity of your pain 0-10 (0=none – 10=severe): circle one- 0 1 2 3 4 5 6 7 8 9 10

Is the pain constant or does it come and go? _____

Have you received any treatment for this condition before seeing us? Yes No

Name of co-treating physician(s): _____

Past Health: (check only those that apply)

- Lower back pain Neck pain Middle back pain Shoulder pain
- Aids/HIV Alcoholism Allergy shots Anemia Anorexia Appendicitis Arthritis
- Asthma Bleeding disorder Breast lump/cancer Bronchitis Bulimia Cancer
- Cataracts Chemical dependency Chicken pox Depression Diabetes Emphysema
- Epilepsy Fractures Glaucoma Goiter Gonorrhea Gout Heart Disease Hepatitis
- Hernia Herniated disc Herpes High Cholesterol Kidney Liver Measles Migraines
- Miscarriage Mononucleosis Multiple Sclerosis Mumps Osteoporosis Pace Maker
- Parkinson's disease Pneumonia Polio Prostate Problems Prosthesis Psychiatric care
- Rheumatoid arthritis Rheumatic fever Stroke Suicide attempt Thyroid Problems
- Tonsillitis Tuberculosis Tumors/Growths(other than cancer) Typhoid fever Ulcers
- Vaginal infections Venereal disease Whooping cough Other: _____

Women only:

Are you pregnant or could you be pregnant? Yes No Nursing? Yes No Birth control? Yes No

Past Surgeries and dates: _____

Current Medications/Supplements and reason: _____

Medical Allergies: _____

Do you smoke? No Yes Drink Alcohol? No Yes

Do you drink/take caffeine? No Yes (Coffee Soda pop Energy drinks pills other: _____)

Do you exercise? No Yes (How much?: mild moderate heavy) Type: _____

I certify to the best of my knowledge the above is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health. I **cannot** find the health care provider negligent if I fail to deliver a full and accurate history of my health.

Patient Signature _____ Print Name _____ Date _____