Profile Information — Step 1 of 3

You are completing the following intake forms: Intake form (updated July 2022)

Please take a moment to fill out our online intake form before your visit. All information is kept completely confidential.

First Name _____ Last Name _____

Preferred Name_____

Prefix / Title … Dr. Mrs. Ms. Miss Mr. Mx.

Email_____

Mobile Phone _____Carrier_____

Please provide at least one phone number. Your mobile number can be used to look up your Account and receive text message appointment reminders.

Home Phone_____

Street Address_____

City_____ State_____ Zip_____

Date of Birth _____ Occupation_____

Guardian_____

Emergency Contact_____ Phone_____

Emergency Contact Relationship_____

Family Doctor_____ Phone (if known)_____

How did you hear about Us?

_____

Questionnaires — Step 2 of 3

Intake form

Check all boxes next to the problems you currently have or have had in the past *Required*

- ☐ Lower back problems
- ☐ Pain between shoulders
- ☐ Neck problems
- ☐ Arm problems
- ☐ Leg problems
- ☐ Swollen joints
- ☐ Painful joints
- ☐ Stiff Joints
- ☐ Sore muscles
- ☐ Weak muscles
- ☐ Walking problems
- ☐ Ruptures
- ☐ Broken bones
- ☐ Bladder trouble
- ☐ Excessive urination
- ☐ Scanty urination
- ☐ Painful urination
- ☐ Discolored urine
- ☐ Vaginal problems
- ☐ Prostate problems
- ☐ Breast problems
- ☐ Currently pregnant
- ☐ Poor appetite
- ☐ Excessive hunger
- ☐ Difficult chewing
- ☐ Difficult swallowing
- ☐ Excessive thirst
- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Black stool
- ☐ Bloody stool
- ☐ Hemorrhoids
- ☐ Liver trouble
- ☐ Gall bladder problems
- ☐ weight troubles
- ☐ Numbness
- ☐ Loss of feeling
- ☐ Paralysis
- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches
- ☐ Muscle jerking
- ☐ Convulsions
- ☐ Forgetfulness
- ☐ Confusion
- ☐ Depression
- ☐ Chest pain
- ☐ Pain over heart
- ☐ Difficulty breathing
- ☐ Persistent cough
- ☐ Coughing blood
- ☐ Rapid heartbeat
- ☐ Blood pressure problems
- ☐ Heart problems
- ☐ Lung problems
- ☐ Varicose veins
- ☐ Eye problems
- ☐ Ear problems
- ☐ Hearing problems
- ☐ Nose problems
- ☐ Throat problems
- ☐ Dental problems

Some Questions To Help Us Help You...

If we could only help you with one health problem, what would that be?

_____

What other health problems would you like us to help you with?

_____

How did these problems start?

_____

When did these problems begin?

_____

Have you ever had these problems before?

_____

Is it worse in the morning or at night?

_____

Do you ever have numbness, tingling or pain in the arms or legs?

_____

How often do you feel the problems you have and how long do they last?

_____

Please list any doctors you've seen for your problems:

_____

Please list any medications you're currently taking:

_____

Please list any surgeries you've had:

_____

Please list any auto or work injuries you've had:

_____

Do you have a family history of cancer, diabetes, heart disease, arthritis, or back problems?

Do you get dizziness? _____ Do you have any heart, lung or stomach problems?

Are you right or left handed? _____ What is your height and weight? _____

Name of previous chiropractor:_____

When were the last x-rays or MRI's taken of your spine? _____

Are you looking for temporary relief or do you want the cause of your problem fully corrected?

What activities or hobbies have you been unable to do because of your problem?

The MANDATORY Orientation Class can be found at (https://www.brightlightnh.com/first-visit) Watch the 10 minute video and answer the following questions

1. What is the name of the man who gave the first adjustment to Harvey Lilard? _____

2. The only thing a Doctor of Chiropractic does is locate and correct _____ _____ .

3. When a Chiropractor moves a bone back into alignment, that is called an _____ .

4. How do you make a dim light bulb BRIGHT? Remove the _____.

5. How do you make an unhealthy person healthier? Remove the _____.

6. Based upon the most current science, how often should you be checked by a Chiropractor for subluxations? Once every _____ to _____ days. *ired*

7. Anything that's good for your health and healing requires time and _____. Chiropractic requires time and _____.

8. I have listed any medical conditions, diseases, pains and symptoms on this intake form and the forms that accompany this quiz. I understand that this office CAN NOT treat me for these things and I hereby certify that i am going to seek care in a medical doctor's office for any medical problems, pain or symptoms I may have now or in the future. I am here in a Chiropractor's office for the sole purpose of getting my spine checked once every 7-14 days to detect and correct subluxations, to remove the interference between the brain and the body so that I can more fully express my innate potential and live my life more fully and become a BRIGHTER LIGHT in this world. My signed name below is evidence that I understand these conditions for care.

Signed_____ Date_____

Consents — Step 3 of 3

Email Communication

You can opt to receive emails to keep you informed of new bookings, changes to your bookings, and reminders for upcoming appointments.

I would like email notifications of new, canceled, and rescheduled appointments
Email 2 days before appointment
Text Message (SMS) 2 hours before appointment

- ☐ **Yes, I would like to receive news and special promotions by email**

Accuracy of Information

- ☐ **I certify that the above medical information is correct to my knowledge.**

Privacy and Sharing of Information

I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to me to personally send to third parties or with my expressed permission.

- ☐ **I agree**

Cancellation policy

Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in the therapists' day that could have been filled by another patient. As such, we require 2 hours notice for any cancellations or changes to your appointment. Patients who provide less than 2 hours notice, or miss their appointment, will be charged a cancellation fee to the card on file.

- ☐ **I am aware of the Cancellation Policy**

Informed Consent

At our office, we have one simple goal- we want to render the highest quality Chiropractic care at the lowest possible fee. In order to accomplish this goal, we have altered some of our business procedures to keep our fees reduced. Please read over these procedures below to understand how our office functions, and to decide if you wish to participate. If you have questions, please direct them to the receptionist.

– You may choose to submit receipts to your insurance company or third party healthcare programs but payment for such services by insurance companies is neither implied nor agreed to by this office. We take no responsibility for non-payment by insurance companies for services rendered in our office.

– Our office will not respond to requests for paperwork for insurance purposes or even acknowledge insurance requests for information on any patient's case to protect your privacy. However, patients may have a copy of their records.

– No balances can be kept or run by patients at any time. Payment is due immediately prior to service being rendered. – All initial visits are paid for upon completion of of these services

– Our office reserves the right to deny services to anyone for any reason, or if the doctor feels that the patient's health is not being best served.

– **I acknowledge that the procedure code used in this office for care is S8990 (adjustment for maintenance rather than restoration)** and I understand that most insurance companies will not reimburse me for my visit even if I submit it myself.

– **I further understand that this office Locates and Corrects Vertebral Subluxations for the purpose of maintaining wellness and optimal function.** I must seek care elsewhere for diagnosis and treatment of pain, symptoms and medical conditions.

– I acknowledge that I am aware that **Bright Light Chiropractic and Dr. Jay Korsen does not provide care for work related injures, automobile accident injures or personal injuries.** I also acknowledge that I must inform this office if I am in an automobile or work injury and I must seek care at my medical doctor's office or another healthcare provider for injuries or conditions sustained. I am also completely aware that Bright Light Chiropractic and Dr. Jay Korsen will not bill, submit claims, nor prepare or submit reports for any automobile, personal or work related injury. I also understand that I am responsible to pay each visit myself at the time of service.

– Further, I understand that Chiropractic care is given to correct misalignments of the spine called SUBLUXATIONS. One of the benefits of Chiropractic adjustments is that you MAY feel better but this is not the GOAL of an adjustment. The goal of an adjustment is to correct SUBLUXATIONS, thereby removing the interference to the nervous system allowing the body to heal itself. As a result, **WE DO NOT TREAT PAIN OR DISEASE OR MEDICAL CONDITIONS; we remove subluxations so the body is able to function optimally and be better enabled to heal itself.**

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a “click” or “pop”, such as the noise when a knuckle is “cracked”, and you may feel movement of the joint.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic care have been described as “rare”, about as often as complications are seen from the taking of a single aspirin tablet. The risk of injury has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures utilized in this office.

Other treatment options which could be considered may include the following:

Over-the-counter analgesics. The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases. Medical care, typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases. Hospitalization in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases. Surgery in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining unadjusted: Delay of chiropractic care allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

I have read the explanation above of chiropractic care. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended care, and hereby give my full consent to care. I will abide by these provisions and I wish to initiate care at this office. I have read and understand the Consent to Initiate Care and agree to all terms. I understand that I am under no obligation to receive or continue care at any time.

Signature_____ Date_____