Brighton Chiropractic and Nutritional Health

1088 Brighton Road Tonawanda, NY 14150 716 837 1711

NEW CLIENT INFORMATION FORM

Please print clearly:

Name:_____
Date:_____

Address:_____

City:_____ State:_____ zip:_____

Home phone:_____ Cell phone:_____

REFERRED BY:_____

Occupation:_____ Employer:_____

Date of Birth:_____ Age:_____ SEX: M/F Height: _____ Weight:_____

Overall health: (Circle one): Excellent/ Good/ Fair/ Poor/ Other

Chief complaint: (reason why you are here):_____

_____

Previous Treatment:_____

Other complaints or problems_____

Current Medications/ Drugs being taken: _____

Are you currently under the care of a physician or other healthcare professionals?
If yes, please give name and date of last visit:_____

Nutritionals Supplements you are taking:_____

_____

Do you smoke, drink coffee or alcohol?

Cigarettes?_____ Coffee?_____ Alcohol?_____

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NAME:_____ DATE:_____

History:
List any major illness(with approximate dates):_____

_____

Past accidents/ Injuries:_____

_____

Marital status: S M D W Name of
Spouse:_____

Describe health of spouse: _____ # of children _____

Name of Child	Age	Sex	Any physical conditions
1_____		M/F	_____
2_____		M/F	_____
3_____		M/F	_____

Any family history of serious illness (circle all those that apply) : Cancer / Diabetes/Heart

Other:_____

Any household pets or other animals you or your family members are in close contact

with:_____

What can we do to make you happier:_____

Sign:_____Date _____

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Permission and Authorization Form regarding the use of "In Light" Light Therapy

Please read before signing:

I specifically authorize the natural health practitioners at Brighton Chiropractic and Nutritional Health to perform Light Therapy in order to assist me in improving my health, **and not for treatment or "cure" of any disease.**

I understand the Light Therapy **is a safe, non-invasive, natural method** of reducing stress, increasing circulation and lymphatic drainage imbalances in the areas that could cause or contribute to various health problems.

I understand that Light Therapy is not a method of "diagnosing" or "treating" disease or other medical conditions, and that these are not being tested for or treated.

No promise or guarantee has been made regarding the results of Light Therapy but rather I understand that Light Therapy is a means by which the lights may aid in decreasing stress, increasing circulation and lymphatic flow, so that safe natural programs can be developed for the purpose of bringing about a more optimum state of health.

I have read and understand the foregoing,

This permission form applies to subsequent visits and consultations.

Date:_____

Print Name:_____

Address:_____

City:_____State:_____Zip:_____

Phone:(_____) _____

Signed:_____

(If you are a minor, signature of parent or guardian is required)