# Bridges Chiropractic Health Clinic

215 18th St. SE, Owatonna, MN 55060 Phone (507) 451-7580 Fax (507) 451-5387

**PATIENT INFORMATION**

DATE _____

Patient _____ Nick Name _____
First Name MI Last Name

SS# _____ DOB _____ ☐ Male ☐ Female

Address _____
Street City State Zip Code

Phone _____ _____ _____
Cell Cell Phone **Provider** (i.e. Verizon) Other (Home/Work)

E-Mail _____

Race: _____ Ethnicity: ☐ Non-Hispanic ☐ Hispanic/Latino Preferred Language: _____

Marital Status: Single Married Divorced Separated Widowed Student: ☐ Yes ☐ No ☐ Full Time ☐ Part Time

Employer _____ Employer Phone _____

Occupation _____

Spouse/Parent_____DOB_____Phone _____

How did you hear about us? Website Location Internet Search Yellow Pages-Qwest Yellow Pages-Dex
Radio Newspaper I was a former patient Friend/Family: _____

Person Responsible for your account ☐ Self ☐ Other _____

Relationship _____ Phone _____

Address _____ City _____ State _____ Zip _____

Emergency Contact Relationship Phone

**INSURANCE INFORMATION** ☐ **Health Insurance** ☐ **NO Health Insurance**

Insurance Co. _____

ID # _____ Group # _____

**Policyholder** _____ **Relationship** _____

**Policyholder DOB** _____ Policyholder Phone _____

Policyholder Address

**ACCIDENT/INJURY INFORMATION**

Is condition due to a recent Accident/Injury? ☐ Yes ☐ No Date of Accident/Injury: _____

Type of Accident/Injury ☐ Auto ☐ Work ☐ Home

☐ Other _____

To whom have you reported this accident? ☐ Auto Insurance ☐ Employer ☐ Work Comp Insurance

☐ Other _____ ☐ Not Reported

Attorney _____

Attorney Address _____

Attorney Phone

**AUTHORIZATION**

*I certify that I have read, understand, and provided correct information to the best of my knowledge.
*I understand that providing wrong information can be dangerous to my health or my child's health.
*I authorize Bridges Chiropractic Health Clinic to release any information to third party payers and/or health practitioners, including diagnosis and the records of treatment or examination rendered to me or my child.
*I authorize and request my insurance company to pay directly to Bridges Chiropractic Health Clinic a/k/a Bridge Street Chiropractic.
*I understand that my insurance carrier may pay less than the actual bill for services received by me or my child.
*I agree to be responsible for payment of all services rendered on my behalf or my dependents.
*I authorize the Doctors and Staff of Bridges Chiropractic Health Clinic to administer such procedures and treatments to me or my child as they deem necessary and they have implied no guarantee of cure.

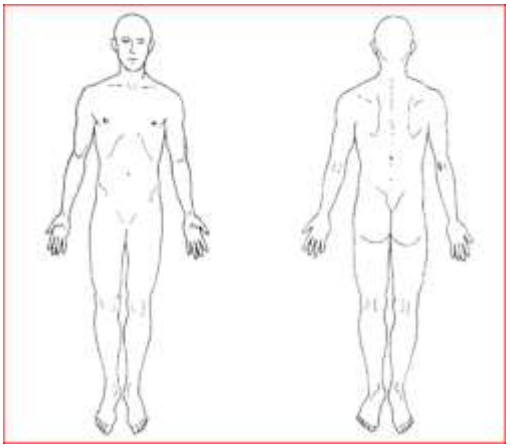
*X* _____ _____
Patient Signature (or Parent/Legal Guardian) Date

_____ _____
Printed Name of Person Signing Relationship to Patient

**Patient Name: _____** **Date: _____**

**PATIENT HISTORY**

Please indicate your areas of pain by drawing an "X" on the diagram →



Does your pain radiate or travel? _No Yes_____
When did pain begin/how long have you had this pain?_____
What caused the pain to begin?_____
Description of Pain:
__Aching __Burning __Cramping __Dull __Numbness __Sharp
__Shooting __Spasm __Stiffness __Throbbing __Tingling
__Other_____
Is the pain: __Constant (100%) __Frequent (75%)
__Occasional (50%) __Intermittent (<25%)
Is the pain: __Severe __Moderate to Severe __Moderate
__Mild to Moderate __Mild
Are your symptoms/condition: __Increasing __Decreasing __Not changing
How would you rate your pain today? (1 =mild 10 = unbearable) **1 2 3 4 5 6 7 8 9 10**
What makes your condition feel better?_____
What makes your condition feel worse?_____
What type of treatment, if any have you tried for this condition? __Chiropractic __Surgical __Physical Therapy
__Medication __Other_____
Other Physician/Clinic treating you for this condition_____
Primary Physician/Clinic _____
Date of last Physical Exam _____ Height _____ Weight _____
Allergies: _____
Medications (Rx & Over the Counter): _____
_____

**PAST HISTORY** Please check **ALL** conditions which have affected you in the past:

__Aids (HIV)
__Aortic Aneurysm
__Arthritis
__Asthma/Lung Disorders
__Bleeding Disorders
__Cancer_____
_____
__Chemical Dependency
__Chronic Sinusitis
__Depression
__Diabetes
__Dizziness/Vertigo
__Epilepsy
__Fractures_____
__Gout
__Headaches
__Heart Disease/Problems
__Heartburn/Indigestion
__Hernia
__Herniated Disc
__High Blood Pressure
__Jaw Pain (TMJ)
__Kidney Disease
__Leg Pain
__Liver Disease
__Low Back Pain
__Miscarriage
__Multiple Sclerosis
__Neck Pain
__Osteoporosis
__Pacemaker
__Prostate Problems
__Psychiatric Care
__Shoulder Pain
__Stroke
__Thyroid Problems
__Upper Back Pain
__Wrist Pain
__Other_____

Surgeries you have had and the date: _____

**FAMILY HISTORY**

__Cancer __Lung Problems __Chronic Headaches __High Blood Pressure __Diabetes
__Rheumatoid Arthritis __Chronic Back Problems __Heart Problems

**HEALTH HABITS**

What do your daily work habits include? __Sitting __Standing __Light Labor __Heavy Labor
Do you consume *alcoholic* beverages? __yes __no drinks/day_____ drinks/week_____
Do you consume *caffeinated* beverages? __yes __no drinks/day_____ drinks/week_____
Do you smoke? __yes __no packs/day_____ packs/week_____ socially_____

**WOMEN ONLY**

Are you currently pregnant? __yes __no Due date_____ Are you nursing? __yes __no