Bridges Chiropractic Health Clinic

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

PATIENT INFORMATION

DATE _____

Patient _____ Preferred Name _____
First Name MI Last Name

Date of Birth _____ ☐ Male ☐ Female Email _____

Address _____
Street City State Zip Code

Cell Ph # _____ Secondary Ph # _____
Other (Home/Work)

Employer _____ Occupation _____

How did you hear about us? Website Location Internet Search Radio Newspaper Event Facebook
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 _____

Patient's Relationship to Policyholder _____**Policyholder DOB** _____

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.

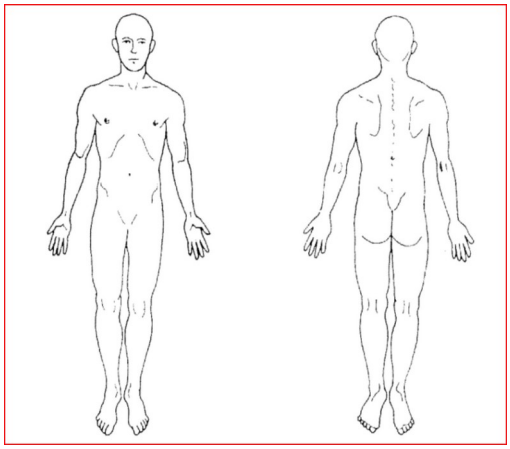
X _____ _____
Patient Signature (or Parent/Legal Guardian) Date

_____ _____
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 to another area? __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 __Stabbing __Stiff __Throbbing __Tingling
__Other_____

Is the pain: __Constant (100%) __Frequent (75%)
__Occasional (50%) __Intermittent (<25%)

Is the pain: __Severe __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_____
Allergies: _____
Medications (Rx & Over the Counter): _____
_____
_____

PAST HISTORY

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

__Aortic Aneurysm
__Arthritis
__Asthma/Lung Disorders
__Bleeding Disorders
__Cancer_____
_____
__Chemical Dependency
__Chronic Sinusitis
__Depression/Anxiety
__Diabetes
__Dizziness/Vertigo
__Epilepsy
__Fractures_____
__Headaches/Migraines
__Heart Disease/Problems
__Heartburn/Indigestion
__Hernia_____
__Herniated Disc
__High Blood Pressure
__Kidney/Liver Disease
__Miscarriage/Infertility
__Osteoporosis
__Pacemaker
__Prostate Problems
__Rheumatoid Arthritis
__Stroke
__Thyroid Problems
__Other_____

___ Chronic Pain: Arm Back (Upper/Mid/Low) Foot Jaw Leg Neck Shoulder Wrist

Fractures and approximate **date**: _____
Surgeries and approximate **date**: _____
Medical Devices/Implants _____

FAMILY HISTORY

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

HEALTH HABITS

What do your daily work habits include? __Sitting __Standing __Light Labor __Heavy Labor
Do you smoke? Yes/No Packs/week_____ Do you use E-cigs? Yes/No

WOMEN ONLY

Are you currently pregnant? Yes/No Due date_____ Are you nursing? Yes/No
Are you currently taking birth control? Yes/No If yes, what kind? _____