Whom may we thank for referring you to this office? _____

APPLICATION FOR CARE AT BRIDGE CHIROPRACTIC

Today's Date: _____ HRN: _____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: _____ Age: _____ ☐Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____ Home Ph: _____ Mobile Ph: _____

HISTORY OF COMPLAINT

Please identify the condition(s) that brought you to this office:

Primary: _____

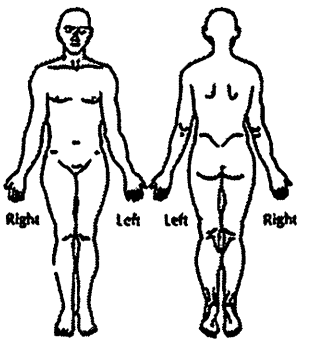
Secondary: _____ Third: _____ Fourth: _____

On a scale of 1 to 10 with 10 being the worst pain and zero being no pain, rate the above complaints by circling the number:

Primary complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Secondary complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Third complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Fourth complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When did the problem(s) begin? _____ When is the problem at its worst? ☐ AM ☐PM ☐mid-day ☐ late PM
How did the injury happen? _____
Condition(s) ever been treated by anyone in the past? ☐ No ☐ Yes If yes, when: _____ by whom? _____
How long were you under care? _____ What were the results? _____

PLEASE MARK the areas on the Diagram with the following letters to describe your symptoms:
R = Radiating B = Burning D = Dull A = Aching N = Numbness S = Sharp/Stabbing T=Tingling



Is your problem the result of ANY type of accident (work, motor vehicle or personal injury)? ☐ Yes ☐ No

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

_____

_____

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? ☐ Yes ☐ No

Other forms of treatment tried: ☐ Yes ☐ No If yes, please state what type of treatment: _____
Who provided it: _____ How long ago? _____ What were the results ☐ Favorable ☐Unfavorable please explain

_____

If you have even been diagnosed with any of the following conditions, please indicate with a P for in the ***Past***, C for ***Currently*** have or N for ***NEVER*** have had:

Broken Bone____ Dislocations____ Tumors____ Rheumatoid Arthritis____ Fracture____ Disability____ Cancer____
Heart Attack____ Osteo Arthritis____ Diabetes____ Cerebral Vascular____ Other serious conditions: _____

Please list any allergies: _____

PLEASE identify ALL PAST and any CURRENT conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES			
SURGERIES			
CHILDHOOD DISEASES			
ADULT DISEASES			
OTHER HOSPITALIZATIONS			

Who is your primary care physician? _____

SOCIAL HISTORY

1. Smoking: ☐cigars ☐ pipe ☐ cigarettes How often? ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
2. Alcoholic Beverage: consumption occurs ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
3. Recreational Drug use: ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
4. Hobbies – Recreations Activities – Exercise Regime: How does your present problem affect? (See ADL form)

FAMILY HISTORY:

1 Does anyone in your family suffer with the same condition(s)? ☐ No ☐ Yes
If yes whom: ☐ grandmother ☐ grandfather ☐ mother ☐ father ☐ sister(s) ☐ brother(s) ☐ son(s) ☐ daughter(s)
Have they ever been treated for their condition? ☐ No ☐ Yes ☐ I don't know

2. Any other hereditary conditions the doctor should be aware of? ☐ No ☐ Yes _____

I hereby authorize payment to be made directly to Bridge Chiropractic, for all benefits which may be payable under a healthcare plan or from any other collateral sources I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Bridge Chiropractic for any and all services I receive at this office.

_____ _____
Patient or Authorized Person's Signature Date Completed

_____ _____
Doctor's Signature Date Form Reviewed

BRIDGE
CHIROPRACTIC
— ALIGNING YOU FOR HEALTH —

Name_____ Date_____

Main Complaint_____

Please answer the following questions listed below (circle all that apply):

How would you describe your average **body temperature**? Normal Hot Warm Cold Cool

Do you **perspire**? Easily Not at all Only on exertion While you sleep

Do you get **headaches**? Often Once in a while Almost never Type/Location_____

Do you have **body aches/pains**? Location_____ Severity (pain scale 1-10) _____
(1 is Low pain (10 is High pain)

Do you have any **chest** complaints? Tightness Palpitations Congestion Pain None

Do you have any **abdominal** complaints? Bloating Gas Pressure Pain None

How is your **appetite**? Normal Strong Weak How many meals per day do you eat? _____
Do you **snack**? How many times per day? _____

How is your **thirst**? Normal Strong Weak How many glasses of water do you drink? _____
What other liquids do you drink? (List all that apply) _____

How is your **urination**? Normal Problematic
Do you wake in the night to urinate? Yes No If yes, how many times? _____

How is your **elimination**? (Check all that apply) Difficult to pass Easy to pass Hard Soft Loose
How many bowel movements do you have per day? _____

How is your **vision**? Normal Problematic
Have you had recent changes in your vision? Yes No
Do you have any floaters in your visual field? Yes No

How is your **hearing**? Normal Problematic
Do you hear any ringing in your ears? High pitch Low pitch None

How is your **sleep**? Good Bad Could be better
How many hours do you sleep? _____ Do you have difficulty falling or staying asleep? Yes No

(Women Only) How is your **menstruation**? Normal Problematic
Pain Before During After None
Clots Yes No
Color _____

On a scale of 1 to 10 (1 = very low 10 = very high) How would you rate your overall **energy** level? _____

Things you NEED to know about acupuncture. There are relatively few negative side effects and/or risks. Initialing and signing below acknowledges the possible risks and gives consent to treat.

Please read through and initial the following statements.

_____Bruising, while not extremely common, can occur.

_____Stimulation of certain acupuncture points can induce labor, **BE SURE TO NOTIFY PRACTITIONER IF YOU ARE OR SUSPECT YOU MAY BE PREGNANT.**

_____Instances of infection have been reported, but are prevented by using single use, disposable needles.

_____Needle "sickness" (dizziness, fainting, and nausea)

_____Organ puncture, including the lung, are extremely unusual occurrences, especially when the treatment is performed by a trained practitioner.

Treatment is to be performed by:
Thomas Betts, B.S., L. Ac., Dipl. Ac., M.S.O.M.

By signing below, I state that I have weighed the risks involved in undergoing treatment and I have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to treatment.

DATED: _____

PATIENT PRINTED NAME: _____

PATIENT or GARDIAN SIGNATURE: _____

WITNESS SIGNATURE: _____ **Date:** _____

OFFICE USE

- ☐ My acupuncture treatment methodology and outcome expectations
- ☐ They were advised to continue with medical care, regardless of my treatment.

Risks:

- ☐ Bruising
- ☐ Organ Puncture
- ☐ Infection
- ☐ Can Induce Labor
- ☐ Needle "sickness" (dizziness, fainting, nausea)
- ☐ Soreness at the site of needle insertion