Dr. Nicholas Mueller, DC
The Bridge Chiropractic
www.thebridgechiro.com

## ADULT APPLICATION FOR CARE

WELCOME TO THE BRIDGE CHIROPRACTIC!

Who may we thank for referring you / how did you hear about us?______________________________________________

Have you received chiropractic care in the past? ☐ No. ☐ Yes (Dr. name)______________________________________

Please fill out the following information completely and to the best of your ability.

Remember to initial the bottom of each page

## PERSONAL INFORMATION

Name: ____________________________________

Preferred Name: ____________________________

Date of Birth: _________________ Age: _________

Gender: ☐ Male ☐ Female

Marital Status: ☐ S ☐ M ☐ D ☐ W

Occupation: _______________________________

Name(s) and Age(s) of Children: __________________________________________________________________

Street Address: _____________________________

City/State/Zip: ______________________________

Email: _____________________________________

Cell Phone: ________________________________

Emergency Contact: __________________________

Cell Phone: ____________ Relationship: __________

## PERSONAL HEALTH HISTORY

Height: ___ft ____in Weight: ________lbs

What is your typical daily work activity?

☐ Sitting ☐ Standing ☐ Working at computer

☐ Manual Labor ☐ Light Lifting ☐ Heavy lifting

☐ Driving ☐ Other: _____________________

Indicate if you have experienced the following:

☐N/A ☐ Been unconscious due to an illness or injury

Serious illnesses, operation, or health emergency

☐ Motor Vehicle Accident ☐ Fractured a bone

Explain and year: __________________________

List any over-the-counter/prescription drugs and vitamins / supplements that you are currently taking:

☐ N/A ______________________________________________________________________________________

Do you have any genetic disorders or disabilities? ☐ No ☐ Yes *If yes, explain:* _______________________________________

## PAST HISTORY

Has your reason for seeking chiropractic care / symptom(s) happened BEFORE? ☐ No ☐ Yes

What treatment did you seek? ______________________________________ ☐ N/A How were your results? ☐ Good ☐ Poor

Are any of the following related to your main issue potentially?

☐ N/A ☐ Past Surgeries ☐ Childhood diseases ☐ Past Injuries Explain: ____________________

Have you ever experienced or been diagnosed with any of the following?

☐ N/A ☐ Pain that wakes you up at night ☐ Night Sweats ☐ Stroke ☐ Heart Attack ☐ Diabetes

## SOCIAL HISTORY

| | | | | |
|---|---|---|---|---|
| Do you smoke? | ☐ Never | ☐ In the Past | ☐ Occasionally | ☐ Daily |
| Are you exposed to secondhand smoke? | ☐ Never | ☐ In the Past | ☐ Occasionally | ☐ Daily |
| Do you drink alcohol? | ☐ Never | ☐ In the Past | ☐ Occasionally | ☐ Daily |
| Do you use recreational drugs? | ☐ Never | ☐ In the Past | ☐ Occasionally | ☐ Daily |
| How often do you exercise? | ☐ Never | ☐ ______ times per week | | ☐ Daily |

## CHIEF COMPLAINT / HISTORY OF PRESENTING ILLNESS

Name: ______________________________________________________ Date: _____________

What is the **MAIN** symptom/reason you are seeking chiropractic care?

PROBLEM/CONCERN #1: ____________________________________________________________

Rate your CURRENT pain/discomfort: ___/10 WHEN did this problem begin?

Did something happen that caused or aggravated the problem? ☐ No ☐ Yes

*If yes, explain:* ______________________________________________________________________

Does the problem RADIATE outward? ☐ No ☐ Yes *If yes, where to?* ___________________________

HOW OFTEN do you experience this problem?

☐ Always ☐ Often ☐ Occasionally ☐ Rarely ☐ Monthly ☐ Weekly ☐ Daily (☐ AM / ☐ PM)

WHEN is the problem at its worst? ☐ Morning ☐ Mid-day ☐ Evening ☐ Other

What makes the problem WORSE? ____________ What makes the problem BETTER ______________

Are there any SECONDARY health concerns you wish to bring to our attention?

PROBLEM/CONCERN #2: ☐ N/A ______________________________________________________

Rate your CURRENT pain/discomfort: ___/10 WHEN did this problem begin?

Did something happen that caused or aggravated the problem? ☐ No ☐ Yes

*If yes, explain:* ______________________________________________________________________

Does the problem RADIATE outward? ☐ No ☐ Yes *If yes, where to?* ___________________________

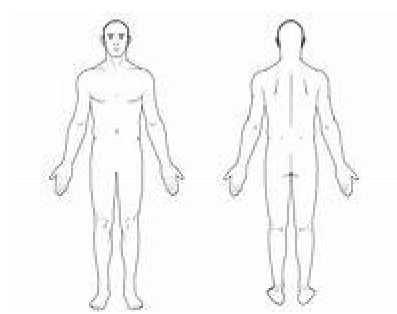
HOW OFTEN do you experience this problem?

☐ Always ☐ Often ☐ Occasionally ☐ Rarely ☐ Monthly ☐ Weekly ☐ Daily (☐ AM / ☐ PM)

WHEN is the problem at its worst? ☐ Morning ☐ Mid-day ☐ Evening ☐ Other

What makes the problem WORSE? ____________ What makes the problem BETTER ______________

Directions: Circle the area(s) where you are experiencing your symptom(s) on the diagram.



How would you describe the problem(s)?

☐ Dull ache ☐ Burning ☐ Deep/boring

☐ Pounding ☐ Stiff/tight ☐ Numb

☐ Radiating ☐ Tingling ☐ Sharp/stabbing

☐ Other: ___________________________________

## CHIROPRACTIC AND HEALTH LIFESTYLE GOALS

What health and lifestyle goals do you hope to achieve while under chiropractic care?

PLEASE CHECK ALL THAT APPLY:

☐ Decrease the *severity and intensity* of my symptom/problem

☐ Decrease the *frequency* of my symptom/problem

☐ By the end of my corrective care, I hope to be able to... ___________________________________

| ACTIVITIES OF DAILY LIVING | | | | | |
|---|---|---|---|---|---|
| DIRECTIONS: Please assess your ability (or lack of) to complete the following activities. | | | | | |
| | **CAN COMPLETE** | | | | |
| | WITHOUT | WITH MINIMAL | WITH SIGNIFICANT | **CANNOT** COMPLETE | N/A |
| **ACTIVITY** | Pain or Difficulty | Pain or Difficulty | Pain or Difficulty | Due to Pain | |
| Bathe/Shower | ☐ | ☐ | ☐ | ☐ | ☐ |
| Groom Hair | ☐ | ☐ | ☐ | ☐ | ☐ |
| Brush Teeth | ☐ | ☐ | ☐ | ☐ | ☐ |
| Use Toilet | ☐ | ☐ | ☐ | ☐ | ☐ |
| Dress Upper Body | ☐ | ☐ | ☐ | ☐ | ☐ |
| Dress Lower Body | ☐ | ☐ | ☐ | ☐ | ☐ |
| Stand | ☐ | ☐ | ☐ | ☐ | ☐ |
| Walk | ☐ | ☐ | ☐ | ☐ | ☐ |
| Sit | ☐ | ☐ | ☐ | ☐ | ☐ |
| Squat | ☐ | ☐ | ☐ | ☐ | ☐ |
| Kneel | ☐ | ☐ | ☐ | ☐ | ☐ |
| Reach Overhead | ☐ | ☐ | ☐ | ☐ | ☐ |
| Bend Forward | ☐ | ☐ | ☐ | ☐ | ☐ |
| Turn ☐ Left ☐ Right | ☐ | ☐ | ☐ | ☐ | ☐ |
| Move from Seated to Standing | ☐ | ☐ | ☐ | ☐ | ☐ |
| Sleep | ☐ | ☐ | ☐ | ☐ | ☐ |
| Eat | ☐ | ☐ | ☐ | ☐ | ☐ |
| Cook | ☐ | ☐ | ☐ | ☐ | ☐ |
| Read | ☐ | ☐ | ☐ | ☐ | ☐ |
| Go Up/Down Stairs | ☐ | ☐ | ☐ | ☐ | ☐ |
| Get In/Out of Car | ☐ | ☐ | ☐ | ☐ | ☐ |
| Drive | ☐ | ☐ | ☐ | ☐ | ☐ |
| Use Computer | ☐ | ☐ | ☐ | ☐ | ☐ |
| Focus/Concentrate | ☐ | ☐ | ☐ | ☐ | ☐ |
| Prepare Food | ☐ | ☐ | ☐ | ☐ | ☐ |
| Household Chores | ☐ | ☐ | ☐ | ☐ | ☐ |
| Lift Children | ☐ | ☐ | ☐ | ☐ | ☐ |
| Carry Bag/Purse | ☐ | ☐ | ☐ | ☐ | ☐ |
| Run/Hike | ☐ | ☐ | ☐ | ☐ | ☐ |
| Sexual Activity | ☐ | ☐ | ☐ | ☐ | ☐ |
| Other: ____________________ | ☐ | ☐ | ☐ | ☐ | ☐ |
| __________________________ | ☐ | ☐ | ☐ | ☐ | ☐ |

## REVIEW OF SYSTEMS AND ORGAN DYSFUNCTION

**DIRECTIONS: Check the box(es) that apply to conditions that you or your family members currently suffer from or have suffered from in the past. (Adopted? ☐ Yes ☐ No)**

| CONDITION | SELF | CHILD | SIBLING | PARENT | GRANDPARENT |
|---|---|---|---|---|---|
| Acid Reflux/Heartburn/Gerd | | | | | |
| ADHD/ADD | | | | | |
| Allergies | | | | | |
| Anxiety | | | | | |
| Arthritis/Joint Pain | | | | | |
| Asthma/Difficulty Breathing | | | | | |
| Autism Spectrum | | | | | |
| Cancer | | | | | |
| Carpal Tunnel Syndrome | | | | | |
| Chest Pain | | | | | |
| Depression | | | | | |
| Difficulty Sleeping | | | | | |
| Disc Problems | | | | | |
| Dizziness/Vertigo | | | | | |
| Ear Problems | | | | | |
| Energy Problems | | | | | |
| Epilepsy | | | | | |
| Fibromyalgia | | | | | |
| Headaches/Migraines | | | | | |
| Hemorrhoids | | | | | |
| High/Low Blood Pressure | | | | | |
| Infertility | | | | | |
| Irritable Bowel Syndrome | | | | | |
| Menstrual Dysfunction | | | | | |
| Mood Changes/Irritability | | | | | |
| Numbness/Tingling | | | | | |
| Scoliosis | | | | | |
| Sinus Problems | | | | | |
| Swelling of Legs/Feet | | | | | |
| TMJ/Jaw Pain | | | | | |
| Tremors | | | | | |
| *Organic / System Problems | | | | | |

**Select ALL that apply:** ☐ Digestive ☐ Endocrine ☐ Gallbladder ☐ Heart ☐ Liver ☐ Stomach ☐ Pancreas

☐ Reproductive ☐ Lung/Respiratory ☐ Urinary ☐ Kidney ☐ Prostate ☐ Vision ☐ Thyroid ☐ Skin

☐ Sexual ☐ Other(s) _____________ Explain: ___________________________________________________

Name: ____________________________________________________________ Date: _____________________

## TERMS OF ACCEPTANCE

Please read the below and if you have any questions, feel free to ask one of our staff members.

## THE BRIDGE CHIROPRACTIC NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal health Information (PHI). In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. Once you have read this notice, please sign and return with the rest of your paperwork. Should you want to keep a copy of this form for your records, you may ask our front desk receptionist to create a copy.

**PERMITTED DISCLOSURES:**

1. Treatment purposes - discussion with other health care providers involved in your care.
2. Inadvertent disclosures - open treating area means open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes - to process a claim or aid in investigation.
5. Emergency - in the event of a medical emergency, we may notify a family member.
6. For Public health and safety - in order to prevent or lessen a serious or imminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement - to identify or locate a suspect, fugitive, material witness or missing person
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons - discussion with coroners and medical examiners in the event of a patient’s death.
10. Telephone calls or emails and appointment reminders - we may call your home and leave messages regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership - in the event this practice is sold, the new owners would have access to your PHI.

**YOUR RIGHTS:**

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive “Detail” Privacy Notice.
3. To request mailings to an address different than residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction
5. To inspect your records and receive one copy of your records at no charge, with notice in advance (72 hours).
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain one copy of your records at no charge, when timely notice is provided (72 hours).

**Name:** ____________________________________________________________ **Date:** ______________________

**Signature:** _________________________________________________________ **Date of Birth:** ________________

## THE BRIDGE CHIROPRACTIC NOTICE REGARDING YOUR RIGHT TO PRIVACY (CONT.)

I have received a copy of The Bridge Chiropractic's Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at any time in the future and will make the new provisions effective for all information that it maintains past and present. I am aware that a more comprehensive version of this "Notice" is available to me by the front desk receptionist at my request. At this time, I do not have any questions regarding my rights or any of the information I have received.

**Signature: ______________________________________________ Date: ______________________**

## INFORMED CONSENT / CONSENT TO TREAT

Chiropractic care, like all forms of health care, while offering considerable benefit, may also provide some level of risk. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures. One of the rarest complications associated with Chiropractic cares occurring at a rate between one instance per one million to one per two million is a cervical spine (neck) adjustment causing injury to a vertebral artery, which could lead to a stroke.

I understand the risks associated with chiropractic spinal adjustments, and the other therapeutic procedures used by the practice to treat my current conditions. All my questions regarding treatment have been answered to my complete satisfaction, and I have conveyed my understanding of all risks to the doctor. After careful consideration, I do hereby consent to chiropractic care by any means, methods, and or techniques the doctor deems necessary to treat my condition(s) at any time throughout the entire clinical course of my care.

**Signature: ______________________________________________ Date: ______________________**

## AUTHORIZATION FOR X-RAYS

X-rays are utilized in the office to help locate and analyze vertebral subluxations. These x-rays are not to be used to investigate for medical pathology. The doctor(s) of The Bridge Chiropractic do not diagnose or treat medical conditions; however if any abnormalities are found, they will be brought to your attention so that you can seek proper medical advice. By my signature below I am acknowledging that the doctor and/or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

**Signature: ______________________________________________ Date: ______________________**

(**Women Only) Please check the box that applies to you** - To the best of my knowledge:

⬜ **I AM NOT Pregnant at this time.** ⬜ **The first day of my last menstrual cycle was on: ____/____/_____ (date)**

⬜ I AM/believe I MAY BE pregnant, therefore I DO NOT Authorize The Bridge Chiropractic to X-ray me at this time.

I have been given a full explanation of when I am mostly likely to become pregnant, and to the best of my knowledge, I am not pregnant. I am consenting to have the diagnostic x-ray examination performed, if necessary. By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the deleterious effects of ionization exposure to an unborn fetus and I have conveyed my understanding of all risks associated with being x-rayed.

**Signature: ______________________________________________ Date: ______________________**

## AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I authorize The Bridge Chiropractic to release all necessary information concerning my health condition to my billing company, insurance company, attorney, and/or adjuster in order to process any claim for reimbursement of charges incurred by me. In addition, I authorize The Bridge Chiropractic to release any information regarding my health condition to other health care providers involved in my care. This assignment will remain in effect until revoked by me in writing. I agree that a photocopy of this form is to be considered as valid as the original. I confirm that all information I have provided is true and correct to the best of my knowledge. I confirm that I have read and fully understand this agreement and authorize Bridge Chiropractic to proceed with chiropractic tests, diagnosis, analysis, and adjustments.

**Signature: ______________________________________________ Date: ______________________**

## AUTHORIZATION OF USE OF / TAKING PICTURES

For valuable consideration, I hereby irrevocably consent to and authorize the use and reproduction by The Bridge Chiropractic, or anyone authorized by The Bridge Chiropractic, of any and all photographs/videos which were taken of myself and my child(ren), for the purposes of promotional TV, website, social media, and/or print ad whatsoever, without further compensation to me. All negatives and positives, together with the prints shall constitute the property of The Bridge Chiropractic, solely and completely. Any information voluntarily provided by a practice member shall also be used in conjunction with the above listed information for purposes previously mentioned. Confidentiality, in regards to any reported conditions, is also waived to the extent of information pertinent to the promotion material only. I authorize The Bridge Chiropractic to share this information via their website and their social media platforms including but not limited to Facebook and Instagram, and for use in the office. All other unrelated practice member information shall remain private and protected (according to Health Information and Privacy Act laws).

**Signature: ______________________________________________ Date: ______________________**