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

PREGNANCY 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: _____ Street Address: _____

Preferred Name: _____ City/State/Zip: _____

Date of Birth: _____ Age: _____ Best Email: _____

Gender: ⬜ Male ⬜ Female Cell Phone: _____

Marital Status: ⬜ S ⬜ M ⬜ D ⬜ W Emergency Contact: _____

Occupation/Employer: _____ Cell Phone: _____ Relationship: _____

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

Hobbies / Activities: _____

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

CONCEPTION / PREGNANCY / BIRTH

Was your baby conceived using IVF? ☐ Yes ☐ No Intended location of birth: ☐ Home ☐ Hospital ☐ Other:_____

Have you received Hormonal medication prior to / for pregnancy? ☐ Yes ☐ No

What is your desired birth plan? ☐ Vaginal ☐ C-Section ☐ VBAC

Please check all that apply to your birth plan: ☐ Epidural ☐ Pain Medication ☐ Placenta delivery ☐ Other: _____

Do you have complicating factors for pregnancy such as: ☐ PCOS ☐ Endometriosis ☐ Obesity ☐ Other: _____

Is there anything else you feel the Doctor should know? _____

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.

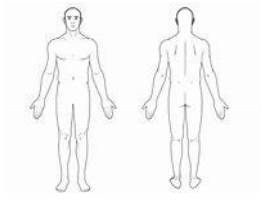
How would you describe the problem(s)?

☐ Dull ache ☐ Burning ☐ Deep/boring

☐ Pounding ☐ Stiff/tight ☐ Numb

☐ Radiating ☐ Tingling ☐ Sharp/stabbing

☐ Other: _____



CHIROPRACTIC AND HEALTH LIFESTYLE GOALS

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

PLEASE CHECK ALL THAT APPLY:

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

☐ By the end of my corrective care, I hope I am better able to... _____

ACTIVITIES OF DAILY LIVING					
DIRECTIONS: Please assess your ability (or lack of) to complete the following activities.					
	CAN COMPLETE				
	WITHOUT Pain or Difficulty	WITH MINIMAL Pain or Difficulty	WITH SIGNIFICANT Pain or Difficulty	**CANNOT** COMPLETE Due to Pain	N/A
ACTIVITY					
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	☐	☐	☐	☐	☐
Turn 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 eminent 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.

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

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at The Bridge Chiropractic, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

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.**

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

Signature: _____ **Date:** _____

FOR RELEASE OF HEALTH INFORMATION AUTHORIZATION

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 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 Reformation 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 Reformation 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:** _____