Bridger Chiropractic Clinic

Dr. Ellen Purser & Dr. Michael Jones

517 S. 22nd Avenue, Suite 7 Bozeman, MT 59718
(406) 587-9122 www.bridgerchiropractic.com fax: (406) 587-9287

Confidential Patient Health History

Today's Date / / Signature of Patient _____

First Name _____ Nick Name _____
Last Name _____ Middle Name _____
Address _____
City _____ State _____ Zip Code _____
Home Phone _____ Work Phone _____
Cell Phone _____ Email _____

Date of Birth / / Age _____ Gender: ☐ Female ☐ Male
Height _____ Weight _____

Marital Status (check one) ☐ Single ☐ Married ☐ Other SS# _____

Emergency Contact _____
Phone _____ Relationship _____

Preferred Contact Method:

☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ Text
May we contact you via text for appointment reminders? ☐ Yes ☐ No

Briefly describe what brings you here today _____
_____
_____

Please list any surgeries _____
_____

Current medications, including dosage if known. (use the back of page if needed)

_____ _____
_____ _____
_____ _____

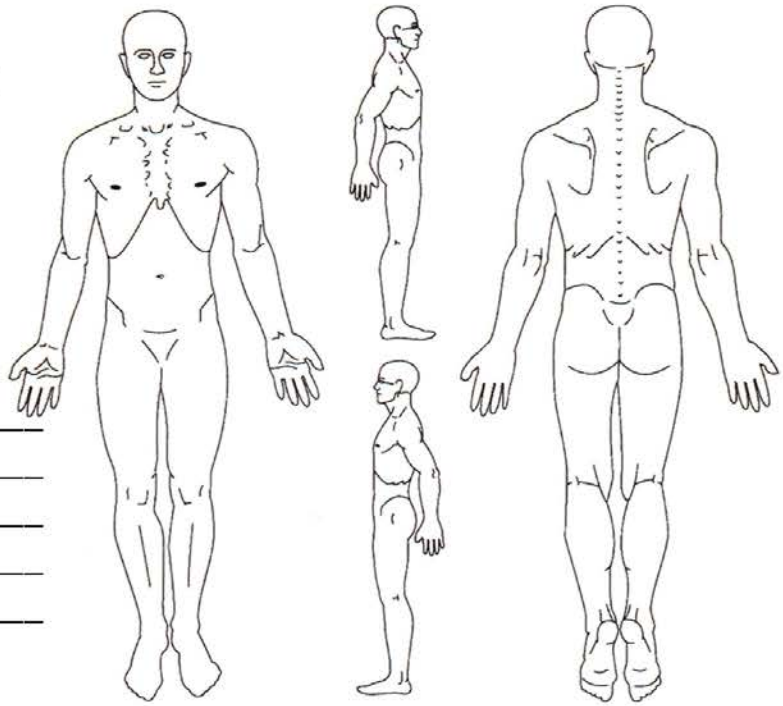
Current Supplements you are taking

_____ _____
_____ _____

Name _____ Date _____

Please draw the location of your discomfort on the images using the symbols shown to represent the type(s) of pain:

D = Dull
B = Burning
N = Numb
A = Ache
R = Radiating
S = Sharp/Stabbing
T = Tingling
C = Cramping
M = muscle spasm



Use your own desriptors to mark image:

_____

_____

_____

_____

_____

On the scales below, please draw a vertical line representing your level of pain or discomfort:

Area	Description	No Pain	Unbearable Pain
_____			
Area	Description	No Pain	Unbearable Pain
_____			
Area	Description	No Pain	Unbearable Pain
_____			

Referred by: _____

Family Medical Doctor: _____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? ☐ yes ☐ no

Name: _____ Date: _____

Health Questionnaire

Please mark with a **N (now)** or **P (past)** in front of the health issue(s) in each list below that you may have experienced or are currently experiencing. Leave blank if you have never experienced the health issue.

Musculoskeletal
___ low back problems
___ pain between shoulders
___ neck problems
___ arm problems
___ leg problems
___ swollen joints
___ painful joints
___ stiff joints
___ weak muscles
___ walking problems
___ broken bones
___ gout
___ arthritis
___ osteoprosis
___ joints replaced
___ TMJ

Gastrointestinal
___ excessive hunger
___ difficulty chewing
___ difficulty swallowing
___ excessive thirst
___ nausea/vomiting
___ abdominal pain
___ diarrhea
___ constipation
___ black stools
___ hemorrhoids
___ liver trouble
___ gall bladder problems
___ bowel problems
___ ulcers
___ bloody stools
___ poor appetite

Genitourinary system
___ bladder trouble
___ excessive urine
___ scanty urination
___ painful urination
___ discolored urine
___ kidney disease
___ lower side pain
___ burning urination
___ frequent urination
___ blood in urine
___ kidney stone
___ irritable bowel syndrome

Endocrine
___ cramps
___ irregular periods
___ vaginal discharge
___ vaginal pain
___ lumps in breast
___ P.M.S.
___ thyroid disease
___ diabetes
___ hair loss
___ menopausal
___ menstrual problems

Ears/Nose/Throat
___ ear noises
___ ear pain
___ dizziness
___ hearing loss
___ sinus infection
___ nosebleed
___ sore throat
___ difficulty swallowing
___ bleeding gums

Cardiovascular
___ chest pain
___ pain over heart
___ rapid heartbeat
___ high blood pressure
___ heart problems
___ varicose veins
___ aortic aneurism
___ heart attack
___ pace maker
___ irregular heartbeat
___ vascular disease
___ poor circulation
___ swelling of legs
___ high cholesterol
___ jaw pain

Respiratory
___ hard to breathe
___ persistent cough
___ coughing blood
___ lung problems
___ asthma
___ tuberculosis
___ shortness of breathe
___ emphysema
___ cold/flu
___ cough/wheezing

Eyes
___ vision problems
___ glaucoma
___ double vision
___ blurred vision

Name: _____ Date: _____

Health Questionnaire (cont)

Please mark with a **N (now)** or **P (past)** in front of the health issue(s) in each list below that you may have experienced or are currently experiencing. Leave blank if you have never experienced the health issue.

Neurological
___ numbness
___ loss of feeling
___ paralysis
___ fainting
___ headaches
___ forgetfulness
___ confusion
___ Babinski
___ stroke
___ seizures
___ head injury
___ brain aneurysm
___ severe headaches
___ pinched nerves
___ Parkinson's disease
___ carpal tunnel
___ spinning/balance

Hematologic/Lymphatic
___ hepatitis
___ blood clots
___ cancer
___ easy bruising
___ easy bleeding
___ fevers/chills/sweats

Allergic/Immunologic
___ hives
___ immune disorder
___ HIV/AIDS
___ allergy shots
___ cortisone use

Constitutional
___ weight loss/gain
___ energy level problem
___ difficulty sleeping

Psychiatric
___ depression
___ anxiety disorder
___ unusual stress

Integumentary
___ skin lesions
___ skin ulcers
___ skin disease
___ eczema
___ psoriasis
___ rashes

When is the last time you were on antibiotics? _____
Reason: _____

Accident information if not work related:
Type of accident (car, bicycle, skiing, fall, etc.) _____
Date and location of accident _____
Is there an attorney involved? _____ If so, name _____
Describe the accident: _____
_____
_____
_____

Work related injury:
Describe the accident _____
Date of injury _____ Have you lost days of work? _____
Have you notified your employer? _____ If yes, name _____
Have you seen any other doctors for this? _____ If yes, name _____
Are you filing a worker's compensation claim? _____ Claim # _____

The Federal Government requires that we ask you the following questions:

Race *(check one)*

❑ White ❑ Black/African American ❑ Hispanic ❑ American Indian/Alaskan Native
❑ Asian ❑ Asian Indian ❑ Chinese ❑ Filipino
❑ Japanese ❑ Korean ❑ Vietnamese ❑ Native Hawaiian or other Pacific Island
❑Samoan ❑ Guamanian or Chamorro ❑Other_____ ❑ I choose not to specify

Multi-Racial *(check one)* ❑Yes ❑No ❑ Unknown

Ethnicity *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

Preferred Language *(check one)*

❑ English ❑ Spanish ❑ American Sign Language ❑ Chinese ❑ French ❑ German
❑ Tagalog ❑ Vietnamese ❑ Italian ❑ Korean ❑ Russian ❑ Polish
❑ Arabic ❑ Portuguese ❑ Japanese ❑ French Creole ❑ Greek ❑ Hindi
❑ Persian ❑ Urdu ❑ Gujarati ❑ Armenian ❑ I choose not to specify

Verification Question *(choose only one question by circling the question, then give the answer to that question)*

❑ What is the name of your favorite pet? ❑ In what city were you born? ❑ What high school did you attend?
❑ What is your favorite movie? ❑ What is your mother's maiden name? ❑ On what street did you grow up?
❑ What was the make of your first car? ❑ When is your anniversary? ❑ What is your favorite color?

Verification Answer to the Chosen question: _____

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker

If yes, how often do you smoke: ❑ Current every day smoker ❑ Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10
No interest *Very Interested*

Has any doctor diagnosed you with Hypertension presently? ❑ Yes ❑ No If yes, describe: _____

_____

Has any doctor diagnosed you with Diabetes presently? ❑ Yes ❑ No If yes, what kind? ❑ Type I ❑ Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? ❑ Yes ❑ No ❑ Not Sure

If yes, other comments regarding Diabetes: _____

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I hereby acknowledge that I have had the opportunity to read and obtain a copy of the Health Insurance Portability and Accountability Act (HIPAA) Privacy rule for Bridger Chiropractic Clinic ***

Patient/Guardian Signature: _____ date:_____
Print Patient Name: _____
Relationship to patient: Self Parent Guardian Responsible Party Legal Representative, etc._____

*** This information is found under the "New Patient Forms" tab as "HIPPA info"

Authorization To Disclose Health Information

As a patient of Bridger Chiropractic Clinic you are protected under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). We may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care or with payment of your health care, but only if you agree that we may do so.

I authorize _____to inquire about:
(print name of parent, significant other, spouse, family member, etc.)

___ Payments/Charges
___ Health Information (prescriptions, test results etc.)
___ Consult with my Doctor regarding my health care

Patient Signature: _____date: _____

Insurance Authorization

I hereby authorize Bridger Chiropractic Clinic to furnish information to my insurance carriers concerning my diagnosis and treatments. I also authorize payments of insurance benefits to be made directly to Bridger Chiropractic Clinic. I understand that I am responsible for all charges incurred.

Patient/Guardian Signature: _____date_____
Print Patient Name: _____
Relationship to Patient: Self, Parent, Guardian, Responsible Party, Legal Representative, Etc. _____