305 NW Englewood Ct #200, Gladstone, MO 64118 • 816-454-5433

PATIENT INFORMATION

Patient name____________________________ Today's date____/____/____

Address____
Street City/State Zip

DOB____/____/______ Age______ Male or Female Marital Status S M D W

Home/Cell Phone Number___________________ e-mail______________________________

Employer imformation__________________________________

INSURANCE INFORMATION

Primary Insurance_________________ ID #__________________ Group #___________

Insurance Holder's name_____________________________
If other than self
Insured's Name____________________ Date of Birth ____/____/____

Relationship to patient________________

Secondary Insurance_______________ID #___________________Group #__________

Insurance Holder's name__________________
If other than self
Insured's Name________________ Date of Birth___________

Relationship to patient________________

EMERGENCY CONTACT

Name______________________________Relationship to Patient_______________

Best number to contact_______________________

PATIENT HEALTH QUESTIONNAIRE

Area of concern bringing you into office today_________________________________

Second area of concern ____________________________________

When/how did your symptoms start____________________________

Pain level (0 being no pain, 10 being unbearable) ⊢0————————5————————10⊣

How often do you experience your symptoms?

- ☐ Constantly (76-100% of the day)
- ☐ Frequently (51-75% of the day)
- ☐ Occasionally (26-50% of the day)
- ☐ Intermittently (0-25% of the day)

What describes the nature of your symptoms?

- ☐ Sharp
- ☐ Shooting
- ☐ Dull ache
- ☐ Burning
- ☐ Numb
- ☐ Tingling

How are your symptoms changing?

- ☐ Getting better
- ☐ Not changing
- ☐ Getting worse

Have you had similar symptoms in the past?

- ☐ Yes
- ☐ No

If you have received treatment in the past for the same or similar symptoms, who did you see?

- ☐ This office
- ☐ Physical Therapist
- ☐ Medical Doctor
- ☐ Other
- ☐ Other Chiropractor

What activities make your symptoms worse?

____

What provides relief for your symptoms?

Below are other services we offer at Bridge. Please check all you'd like to learn more about:

☐ Regenerative Medicine ☐ Weight Loss ☐ Low Energy

☐ Poor Immune System ☐ Fitness/Flexibility Class

Reverse side →

For each condition listed below, please mark present or past

If nothing applies, please leave blank

Past	Present	
☐	☐	Headaches
☐	☐	Neck pain
☐	☐	Upper back pain
☐	☐	Mid back pain
☐	☐	Low back pain
☐	☐	Shoulder pain
☐	☐	Elbow/Upper arm pain
☐	☐	Wrist pain
☐	☐	Hand pain
☐	☐	Hip/Upper leg pain
☐	☐	Knee/Lower leg pain
☐	☐	Ankle/foot pain
☐	☐	Jaw pain
☐	☐	Joint swelling/Stiffness
☐	☐	Arthritis
☐	☐	Rheumatoid Arthritis
☐	☐	General fatigue
☐	☐	Muscular Incoordination

Past	Present	
☐	☐	Abnormal weight gain/Loss
☐	☐	Loss of Appetite
☐	☐	Abdominal Pain
☐	☐	Ulcer
☐	☐	Hepatitis
☐	☐	Liver/Gallbladder Disorder
☐	☐	Cancer
☐	☐	Tumor
☐	☐	Asthma
☐	☐	Chronic Sinusitis
☐	☐	Diabetes
☐	☐	Excessive Thirst
☐	☐	Frequent Urination
☐	☐	Allergies
☐	☐	Depression

- ☐ ☐ Visual Disturbances
- ☐ ☐ Dizziness

- ☐ ☐ High Blood Pressure
- ☐ ☐ Heart Attack
- ☐ ☐ Chest pains
- ☐ ☐ Stroke
- ☐ ☐ Angina

- ☐ ☐ Kidney Stones
- ☐ ☐ Kidney Disorders
- ☐ ☐ Bladder Infection

- ☐ ☐ Systemic Lupus
- ☐ ☐ Epilepsy
- ☐ ☐ Dermatitis/Eczema/Rash
- ☐ ☐ HIV/AIDS

Females Only

- ☐ Birth control pills
- ☐ Hormonal Replacement
- ☐ Pregnancy(Past or present)

☐ **Other History**____

→Patient social history

Alcohol Use	☐ Never	☐ Rarely	☐ Moderate	☐ Daily
Tobacco Use	☐ Never	☐ Rarely	☐ Moderate	☐ Daily
Drug Use	☐ Never	☐ Rarely	☐ Moderate	☐ Daily

Family Medical History

	Age	Disease	If deceased, cause of death
Father	_____		
Mother	_____		
Siblings	_____		
Children	_____		

Please list all allergies/reactions to any medication or food

______________________ ______________________ ______________________
______________________ ______________________ ______________________

List all of your prescription and over the counter medications and the dosage

Please include any vitamins or supplements(may include separate list)

______________________ ______________________ ______________________
______________________ ______________________ ______________________

List all surgical procedures you have had or times you have been hospitalized in the last 5 years

______________________ ______________________ ______________________
______________________ ______________________ ______________________

Additional Comments:

Patient signature ________________________________ Date _____/_____/_____

Reverse side →

Office use only

BP P T O2 H W

D.C.'s signature ______________________________ Date____/____/_____
N.P.'s signature ______________________________ Date____/____/_____

INSURANCE CONSENT
I hereby authorize the release of information to my insurance company and payments to be made directly to my physicians. This form may be used for all of my insurance companies and I authorize this practice to act as my agent to help me secure payment from my insurance companies. I understand that I am responsible for my bill and am subject to attorney fees, collection fees/charges and any other charges incurred if my portion of the balance is not paid when due.

__________ Initial

CONSENT FOR TREATMENT
I authorize the doctor(s) to perform such diagnostic procedures and to administer what treatment is necessary to treat my present condition. I have been informed of many of my options, including the option to do nothing.

__________ Initial

PATIENT CONSENT TO LEAVE MESSAGES
BRIDGE Integrative Medicine, in order to comply with the privacy laws, must receive a patient authorization before leaving detailed messages for the patient on an answering machine, voicemail or with a live person. This practice is meant to protect the privacy of the patient and to protect the physicians and staff of BRIDGE Integrative Medicine from violating the patient's confidentiality. If there is not a signed consent on file, staff will only leave their name and telephone number. By initialing, you are allowing the staff at Bridge Integrative Medicine to leave a message on an answering machine, voicemail, specified individual, which may include sensitive and/or protected health information.

____ on an answering machine/voicemail at home/cell phone
____ on an answering machine/voicemail at work
____ with ______________________________ relationship
____ I do not consent to messages being left

__________ Initial

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I was presented with a copy of the Notice of Privacy Practices of Bridge Integrative Medicine LLC. Our Notice of Privacy Practices provides information on how we may use and disclose your protected health information. We encourage you to read it in full. Our Notice of Privacy Practices is subject to change. The most current version is on display in the office at all times. Bridge Integrative Medicine LLC may use protected health information for the following reasons: marketing, internal referral board, testimonials or pictures on the bulletin board; however, we will present you with a separate form and have a conversation with you if we wish you use your likeness or image within our office or marketing materials. __________ Initial

MEDICAL RECORDS RELEASE AUTHORIZATION

I authorize Bridge Integrative Medicine to release my information concerning my health and services rendered to the appropriate person or medical office/hospital.

Name of person or office authorized to receive your records

______________________________(Name) ______________________________(Relationship)

______________________________(Name) ______________________________(Relationship)

______________________________(Clinic/Office) ______________________________(Provider's Name)

Patient signature______________________________ Date__________

Witness signature______________________________ Date__________