



Dr. David B. Bridgwood

Chiropractor



417 W. Merrick Road
Valley Stream, NY, 11580
Office: (516) 561 – 4060 | Fax: (516) 561-5392
www.BridgwoodChiropractic.com

Patient Information

Name

 Last First

Sex: M F Age _____ D.O.B. _____

Patient SS# _____ HT: _____ WT: _____

Single Married Widowed Separated Divorced

Address

 City State Zip

Phone : _____ (Home)
 _____ (Cell)

Email : _____

Occupation: _____

Employer: _____

Employer Address

City State Zip

Employer Phone: _____ **Ext:** _____

Spouse Name:

 Last First

D.O.B: _____ **SS#** _____

Whom may we thank you for referring?

 Last First

Insurance

Who is responsible for this account? Self Other _____
 Last First

Insurance Co. _____ **ID#** _____ **Group#** _____

Is Patient Covered by additional Insurance? Yes NO

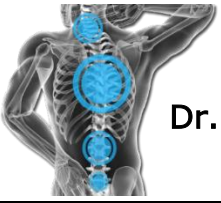
If Yes, Insurance Co. _____ **ID#** _____ **Group#** _____

Assignment And Release

I, the undersigned certify that I (or my dependent) have insurance covered with the above list insurance(s) and assign directly to **DR. DAVID B. BRIDGWOOD** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits I authorize the use of this signature on all insurance submissions.

Responsible Party Signature Relationship Date

When "I" is replaced by "We" Even "Illness becomes Wellness"



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Accident Information

Is condition due to accident? NO Yes Date: _____

Type of Accident Auto Work Home Other

To whom have you made a report of your accident? Auto Insurance Work Worker Comp. Other

Location of accident? _____
Address State ZIP

Attorney Name (If Applicable) _____ Phone# _____

Patient Condition

Reason for visit? _____

When did your symptoms appear? _____

Is condition getting progressively worse? Yes No

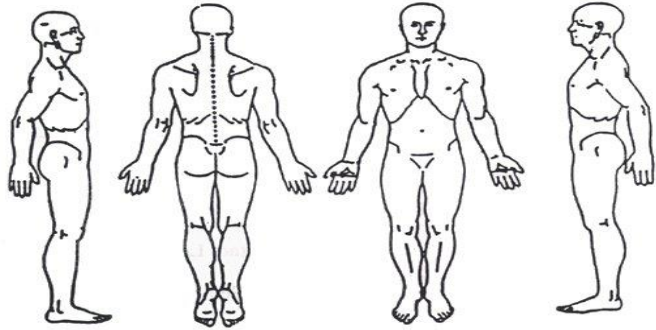
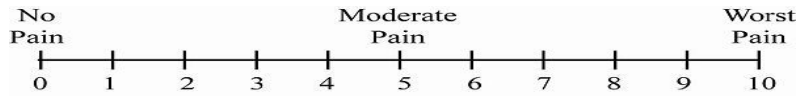
*Mark an on the picture where you continue to have pain, numbness or tingling.

- Type of pain: Sharp Dull Throbbing
- Numbness Aching Shooting Burning
- Tingling Cramps Stiffness Swelling
- Other _____

How often do you have pain? _____

Is it constant or does it come and go? yes NO Does your pain interfere with Work Sleep Daily Recreation

Activities or movements that are painful to perform Sitting Standing Walking Bending Lying Down



History

What treatment have you received for your condition? Medications Surgery Physical Therapy Chiropractic

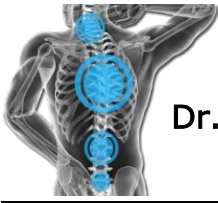
Other _____ None

Name and Address of other doctor(s) who have treated for this condition _____

Date of last visit: Physical Exam _____ Spinal Exam _____ Dental X-Ray _____

Spinal X-Ray _____ Chest X-Ray _____ Urine Test _____ Blood Test _____

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Place a mark on “Yes” or “No” to indicate if you have had any of the following :

Aids/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alcoholism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mononucleosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergy Shots	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fractures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mumps	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors, Growths	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anorexia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Goiter	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Typhoid Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Appendicitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gonorrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Goiter	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson’s Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vaginal Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pinched Nerve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Whooping Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breast Lump	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Polio	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other:	
Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prostate Problem	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Bulimia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herniated Disk	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prosthesis	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Chicken Pox	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No		
		Measles	<input type="checkbox"/> Yes <input type="checkbox"/> No	Suicide Attempt	<input type="checkbox"/> Yes <input type="checkbox"/> No		

EXERCISE
 None
 Moderate
 Daily
 Heavy

WORK ACTIVITY
 Sitting
 Standing
 Light Labor
 Heavy Labor

HABITS
 Smoking Packs/Day _____
 Alcohol Drinks/Week _____
 Coffee/Caffeine Drinks Cups/Day _____
 High Stress Level Reason _____

Are You Pregnant? Yes No Due Date _____

Injuries/Surgeries (List all Falls, Head Injuries, Broken Bones, Dislocations, Surgeries, etc....)

MEDICATIONS

ALLERGIES

VITAMINS/HERBS/MINERALS

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