CHIROPRACTIC express

DR. CRAIG J. BURGARDT, D.C.

2886 Tamiami Trail, Suite 6
Port Charlotte, FL 33952

(941) 249-9020

www.chiropracticexpress.com

APPLICATION FOR TREATMENT

Date: ______________________

First Name: ______________________ Last Name: ______________________

Preferred Name/Nickname: ______________________ Date of Birth: ______/______/______ Age: ________

Street Address: ____

City: ______________________ State: __________ Zip Code: ______________

Phone Number: ______________________ Secondary Phone: ______________________

Email: ______________________ ☐ I consent to office communications by phone/text/email.

Emergency Contact Name: ______________________ Contact Phone No: ______________________

Primary Care Physician: ______________________ Medicare Eligible? ☐ Yes ☐ No (Check One)

Occupation: ______________________ Hobbies: ______________________

How did you find us, were you referred by somebody? ______________________

Have you ever received Chiropractic care? ☐ Yes ☐ No If YES, When? ______________

ABOUT YOUR CONDITION

Primary Reason for Today's Visit: ______________________

When did your symptoms begin? ______________________

How did this condition start? (Check all that apply)

☐ Gradually Over Time ☐ Lifting Injury ☐ Sports/Exercise ☐ Fall

☐ Auto Accident ☐ Work Injury ☐ Unknown ☐ Other: __________

Current Symptoms: (Check all that apply)

☐ Pain ☐ Numbness ☐ Tingling ☐ Weakness ☐ Stiffness

☐ Headaches ☐ Muscle Spasms ☐ Limited Motion ☐ Other: __________

Is your pain/discomfort: ☐ Constant (always present) ☐ Intermittent (comes and goes)

Please rate your pain/discomfort level on a scale of 1 – 10 (1 = low pain; 10 = severe pain)

1	2	3	4	5	6	7	8	9	10

Aggravating Factors (What makes it worse?): ______________________

____

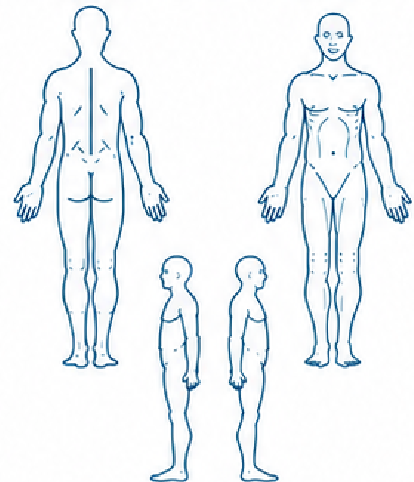
Relieving Factors (What makes it better?): ______________________

____

Have you had this pain in the past? ☐ Yes ☐ No If YES, When? __________

PLEASE DRAW THE LOCATION OF THE PAIN ON THE FIGURES BELOW.

Use an X or circle the affected area(s)



TYPE OF PAIN (Mark all that apply and use symbols on diagram)

☐ Dull/Ache (xx) ☐ Pins 'n' Needles (//) ☐ Stabbing (^^)

☐ Spasms (#) ☐ Tight (==) ☐ Numbness (oo)

☐ Burning (++) ☐ Shooting (TT) ☐ Weakness (--)

☐ Can't Describe (??)

CHECK ONE:

☐ **PAIN RELIEF CARE ONLY**

Usually requires 1–2 visits per week up to six weeks for the quickest results. Your adjustment frequency depends entirely on your health goals, your finances and your convenience.

☐ **PAIN RELIEF + PREVENTATIVE CARE**

1–2 times per week visits up to six weeks and then consistent adjustments every few weeks to every few months. These regular adjustments may help reduce the chance of spinal-related symptoms returning.

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HEALTH HISTORY & LIFESTYLE

1. HAVE YOU EVER HAD OR BEEN DIAGNOSED AS HAVING: (Check "Y" for Yes or "N" for No)

☐ Y	☐ N	Broken Bones	☐ Y	☐ N	Seizure	☐ Y	☐ N	Herniated / Bulging Disc
☐ Y	☐ N	Circulatory Problems	☐ Y	☐ N	Hand / Foot Neuropathy	☐ Y	☐ N	Diabetes
☐ Y	☐ N	Rheumatoid Arthritis	☐ Y	☐ N	Pacemaker / Defibrillator	☐ Y	☐ N	Pregnancy
☐ Y	☐ N	Osteoarthritis	☐ Y	☐ N	Heart Disease	☐ Y	☐ N	Cancer / Tumor
☐ Y	☐ N	Osteoporosis / Osteopenia	☐ Y	☐ N	Stroke / TIA	☐ Y	☐ N	Substance Abuse History
☐ Y	☐ N	Congenital Disease	☐ Y	☐ N	Gall Bladder Problems	☐ Y	☐ N	Eating Disorder
☐ Y	☐ N	Bruising or Bleeding Disorder	☐ Y	☐ N	Ulcers / GERD	☐ Y	☐ N	Depression / Anxiety
☐ Y	☐ N	High / Low Blood Pressure	☐ Y	☐ N	Persistent / Respiratory Problems	☐ Y	☐ N	Headaches / Migraines
☐ Y	☐ N	High Cholesterol	☐ Y	☐ N	Tuberculosis	☐ Y	☐ N	Dizziness / Vertigo
☐ Y	☐ N	Hepatitis	☐ Y	☐ N	Chronic Fatigue	☐ Y	☐ N	HIV / AIDS

If you answered "YES" to any of the above, please EXPLAIN:

____

____

____

2. LIFESTYLE & GENERAL HEALTH

Do you smoke or vape? ☐ Yes ☐ No If yes, how much? __________ For how long? __________

Do you drink alcohol? ☐ Yes ☐ No If yes, how much? __________ How often? __________

Do you have any allergies? ☐ Yes ☐ No If yes, please list: __________

Are you currently pregnant? ☐ Yes ☐ No If yes, how many months? __________ Any complications? __________

Height: __________ **Weight:** __________ **Are you currently taking blood thinners?** ☐ Yes ☐ No
(Examples: Eliquis, Xarelto, Warfarin, Aspirin, etc.)

Exercise Activity Level: ☐ None ☐ Light ☐ Moderate ☐ Heavy **Type:** __________

Sleep Quality: ☐ Good ☐ Fair ☐ Poor Average hours of sleep per night: __________

Do you currently have any active personal injury, auto accident, or workers compensation claims? ☐ Yes ☐ No

3. ALLERGIES (Check all that apply)

☐ None Known ☐ Medication
☐ Food ☐ Environmental

Please list: __________

____

____

4. ADDITIONAL HEALTH INFORMATION

Do you have any artificial joints or implants?	☐ Yes	☐ No	If yes, please specify: __________
Do you have any metal implants or hardware?	☐ Yes	☐ No	If yes, please specify: __________
Do you have a history of fractures?	☐ Yes	☐ No	If yes, please specify: __________
Do you have any skin conditions or rashes?	☐ Yes	☐ No	If yes, please specify: __________
Do you have any numbness or tingling?	☐ Yes	☐ No	If yes, please specify: __________
Do you experience dizziness or fainting?	☐ Yes	☐ No	If yes, please specify: __________

5. FAMILY HISTORY (Check all that apply)

☐ Arthritis ☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure ☐ Stroke

☐ Osteoporosis ☐ Other: __________ ☐ None Known

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PRIOR CARE, MEDICATIONS & HISTORY

1. LIST ALL SURGERIES (Location on Body & Reason)

Location on Body & Reason	Date of Surgery
1.	
2.	
3.	

2. LIST ANY ACCIDENTS, MAJOR INJURIES OR TRAUMAS (Describe below)

1. ______________________________
2. ______________________________
3. ______________________________

3. LIST CURRENT MEDICATIONS AND THE CONDITION TREATED

Medication / Drug	Condition Treated	Medication / Drug	Condition Treated

Do you take any over-the-counter medications, vitamins, or supplements? ☐ Yes ☐ No If yes, please list: ______________

4. PREVIOUS IMAGING RELATED TO THIS CONDITION

Have you had any imaging performed?

☐ Yes ☐ No ☐ Not Sure

If yes, check all that apply:

☐ X-Ray ☐ MRI ☐ CT Scan ☐ Other: __________

Approximate Date(s): ______________________

Where was it performed? ______________________

What were the results? ______________________

____

5. PREVIOUS TREATMENT FOR THIS CONDITION

Have you had any previous treatment for this condition?

☐ Yes ☐ No

If yes, check all that apply:

☐ Chiropractic Care ☐ Injections
☐ Physical Therapy ☐ Acupuncture
☐ Medical Doctor / Primary Care ☐ Surgery
☐ Massage Therapy ☐ Other: __________

Approximate Date(s): ______________________

Did you receive relief? ☐ Yes ☐ No If yes, how long? __________

Please describe: ______________________

6. LAST PHYSICAL EXAM

When was your last physical exam? ______________ By whom/where? ______________

Were there any abnormal findings? ☐ Yes ☐ No If yes, please explain: ______________

7. ADDITIONAL HEALTH INFORMATION

Do you have a history of cancer? ☐ Yes ☐ No If yes, please explain: ______________

____

Have you ever been hospitalized for a serious medical condition? ☐ Yes ☐ No If yes, please explain: ______________

____

Do you have any other medical conditions not listed elsewhere in this packet? ______________

____

____

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OFFICE POLICIES & FINANCIAL INFORMATION

Date: ______________

Please read carefully. These policies help us provide you with the best possible care and a smooth experience.

PAYMENT POLICY

- Payment is due at the time of service unless other written arrangements have been made.
- We accept cash, major credit/debit cards, and HSA/FSA cards.

ACCEPTED PAYMENT METHODS

CARE PLAN & TREATMENT

- Your doctor will recommend a care plan based on your condition and goals.
- You are in charge of your care. You may accept or refuse any recommendation.
- Individual responses to chiropractic care may vary.
- Attending care on a regular basis is important for optimal results.

COMMUNICATION

- Please keep us updated on any changes in your health information.
- Inform us if you are seen by another healthcare provider for the same condition.
- We respect your time and privacy. Please be respectful of our team and other patients.

PATIENT RESPONSIBILITIES

- Provide accurate and complete information.
- Follow through with recommended care.
- Ask questions! We are here to help.
- Let us know if you have any concerns about your care.

NOTICE

We reserve the right to modify these policies at any time. Any changes will be posted in the office and on our website.

Thank you for choosing Chiropractic Express. We appreciate your trust and the opportunity to care for you.

OPEN ROOM TREATMENT AGREEMENT

I understand that care may be provided in an open treatment area and that other patients may be present. The office will make reasonable efforts to protect my privacy.

Our treatment area is an open room with multiple tables. This allows our team to provide efficient care and maintain a welcoming, community atmosphere. You may be treated in the same room as other patients.

By signing below, you acknowledge and agree that you understand the nature of our open room treatment setting and consent to receive care in this environment. If you have any questions or concerns, please let us know.

SCOPE OF CARE

Our office focuses on maintenance and minor conditions to support your overall wellness and help you stay active. We do not treat acute injuries, severe pain, or conditions that require extensive medical management. Your first visit includes a consultation and examination. If the examination and your history determine that you are a candidate for chiropractic care, an adjustment will be performed during that visit.

FINANCIAL AGREEMENT & ACKNOWLEDGEMENT

I understand and agree to the policies listed above. I am responsible for all charges for services rendered. I also understand that if my account is sent to collections, I will be responsible for all collection fees and legal costs.

I have read the office policies, open room treatment agreement, scope of care, and financial agreement listed above. I understand and agree to these policies and have had the opportunity to ask questions regarding them.

Patient Signature	Printed Name	Date
______________________	______________________	______________

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INFORMED CONSENT TO CARE

Date: ______________

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

PATIENT ACKNOWLEDGEMENT & CONSENT

Patient Name: ______________________ Signature: ______________________ Date: __________

Parent or Guardian: ______________________ Signature: ______________________ Date: __________

Witness Name: ______________________ Signature: ______________________ Date: __________

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ACKNOWLEDGEMENT OF PRIVACY POLICY

OUR PRIVACY POLICY

We are committed to protecting the privacy of your personal health information. Our Notice of Privacy Practices describes how we may use and disclose your health information and how you can access this information. Please review our Notice of Privacy Practices, which is available to you at the front desk, on our website, or upon request.

I ACKNOWLEDGE THAT:

- I have received or been offered a copy of the Notice of Privacy Practices.
- I have been given the opportunity to read and understand the Notice of Privacy Practices.
- I understand that the Notice of Privacy Practices describes how my health information may be used and disclosed.
- I understand that I have the right to review the Notice of Privacy Practices prior to signing this Acknowledgement.
- I understand that Chiropractic Express may change its privacy practices at any time and that I may request a current copy of the Notice of Privacy Practices at any time.
- I understand that I may request restrictions on how my health information is used or disclosed for treatment, payment, or healthcare operations, but that Chiropractic Express is not required to agree to those requested restrictions.
- I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on this authorization.

PATIENT ACKNOWLEDGEMENT

By signing below, I acknowledge that I have received or been offered a copy of the Notice of Privacy Practices for Chiropractic Express – Dr. Craig J. Burgardt, D.C. I understand the information contained in the Notice of Privacy Practices and my rights regarding the use and disclosure of my health information.

______________________________	______________________________	______________________________
Patient or Legal Guardian Signature	Print Name	Date

AUTHORIZED REPRESENTATIVE (If applicable)

If you are signing as the patient's authorized representative, please describe your relationship to the patient.

Relationship to Patient: ______________________________

______________________________	______________________________	______________________________
Signature of Authorized Representative	Print Name	Date

IMPORTANT NOTICE: *We respect your privacy and are committed to safeguarding your personal health information in accordance with all applicable federal and state laws.*