

# Chiropractic eXpress

Dr. Craig Burgardt - Chiropractic Physician  
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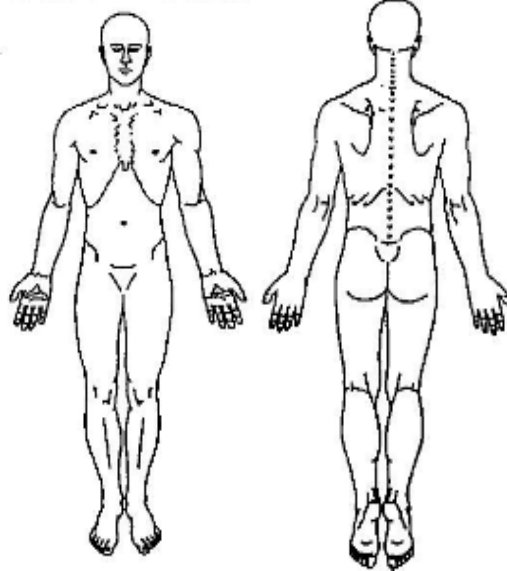
Date: \_\_\_\_\_  
 First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Nickname: \_\_\_\_\_  
 Street Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ Secondary Phone: \_\_\_\_\_  
 Email Address: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Hobbies: \_\_\_\_\_  
 Emergency Contact Name: \_\_\_\_\_ Contact Phone No: \_\_\_\_\_  
 Are you a Medicare Eligible Patient: Yes \_\_\_\_\_ No \_\_\_\_\_ (Check One)  
 How did you find us, were you referred by somebody? \_\_\_\_\_  
 Have you ever received Chiropractic care? YES \_\_\_\_\_ NO \_\_\_\_\_ If YES, When? \_\_\_\_\_  
 What brings you to my office? Condition: \_\_\_\_\_ Onset Date: \_\_\_\_\_  
 What makes it better? (ice, heat, medication, etc.) \_\_\_\_\_  
 What makes it worse? (bending, sports, ice, heat, etc.) \_\_\_\_\_  
 Have you had this pain in the past? (Y or N) \_\_\_\_\_ If YES, When? \_\_\_\_\_  
 Rate the degree of your pain on a scale of 1 – 10 (1-low pain; 10 – severe pain) 1 2 3 4 5 6 7 8 9 10

**Type of Pain: (Mark on diagram with associated symbols and place pain scale number on all that apply)**

\_\_\_\_ Dull/Ache(xx)    \_\_\_\_ Pins 'n' Needles(//)    \_\_\_\_ Stabbing(^^)  
 \_\_\_\_ Spasms(#)    \_\_\_\_ Tight(==)  
 \_\_\_\_ Numbness(00)    \_\_\_\_ Burning(++)  
 \_\_\_\_ Shooting(TT)    \_\_\_\_ Weakness (~~)    \_\_\_\_ Can't Describe (??)

Check One: \_\_\_\_\_ Pain is Constant or \_\_\_\_\_ Pain comes and goes

**Please draw the location of the pain on the figures below. Use an X or circle the affected area(s)**

<p><b>Check One:</b>        _____ I want pain relief ONLY</p> <p>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.</p> <p>_____ I want pain relief AND regular preventative adjustments following pain relief.</p> <p>1-2 times per week visits up to six weeks and then consistent adjustments every few weeks to every few months. These regular adjustments are important to prevent symptoms from returning from spinal related symptoms.</p>	
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Application for Treatment

Have you ever had or been diagnosed as having: (Circle 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	Y N Women: Pregnant
Y N Osteoarthritis	Y N Heart Disease	Y N Cancer/Tumor
Y N Congenital Disease	Y N Stroke/TIA	Y N Drug Addiction
Y N Bruising or Bleeding	Y N Gall Bladder	Y N Eating Disorder
Y N High/Low Blood Pressure	Y N Ulcers	Y N Depression
Y N High Cholesterol	Y N Persistent Cough	Y N Headaches
Y N Hepatitis	Y N Tuberculosis	Y N HIV/AIDS

Please EXPLAIN ALL "YES" answers that you have circled above:

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Do you smoke/vape? \_\_\_\_\_ how much? \_\_\_\_\_ Do you Drink Alcohol? \_\_\_\_\_ How Much? \_\_\_\_\_

Do you have any allergies? \_\_\_\_\_ What allergies? \_\_\_\_\_

Are you currently pregnant? \_\_\_\_\_ How many months? \_\_\_\_\_ Any Complications? \_\_\_\_\_

Have you been in an auto accident in the last 14 days or have any open claims for auto injuries or workers compensation cases? (yes or no) \_\_\_\_\_

List All Surgeries: Location on Body & Reason:

1. \_\_\_\_\_ Date: \_\_\_\_\_
2. \_\_\_\_\_ Date: \_\_\_\_\_
3. \_\_\_\_\_ Date: \_\_\_\_\_

List Any Accidents, Major Injuries or Traumas: Describe below

1. \_\_\_\_\_ Date: \_\_\_\_\_
2. \_\_\_\_\_ Date: \_\_\_\_\_

List Current Medications and the Condition Treated (purpose)

Drug	Condition	Drug	Condition

When was your last physical exam? \_\_\_\_\_. By whom/where: \_\_\_\_\_

**WELCOME - - - WE ARE GLAD YOU ARE HERE!!**

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

I understand that Chiropractic Express is a very specialized chiropractic office by not accepting any forms of insurance, which allows providing spinal adjustments for a discounted fee to help achieve and maintain optimized health; therefore, I further understand that Dr. Burgardt does NOT offer to treat or diagnose any disease or condition other than misalignment of the body's vertebra. I understand that my visits are NOT covered by any insurance or Medicare/Medicaid and Dr. Burgardt will NOT complete reimbursement forms.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

Please read and agree to the following by: **INITIALING EACH BLANK**

YES \_\_\_\_\_ Minor Pain, Prevention and Maintenance Care Only

I understand that Chiropractic Express is very specialized, serving patients who want regular chiropractic adjustments for non-severe pain, prevention, and maintenance care. Dr. Burgardt may not accept my case if I am in severe pain, if I have been in an accident or if my condition requires treatment not available in office (If x-rays or other imaging are required, patients will not be seen until these have been processed and reviewed). These cases require personal injury chiropractic or medical care. If I am not a candidate for express care, Dr. Burgardt will refer me to the most appropriate care provider.

YES \_\_\_\_\_ Fees are NOT Covered by Insurance or Medicare

I understand that my first visit fee is: \$60, then \$\$40 per visit thereafter, always paid in advance at sign-in. Fees are subject to increase without notice. I understand that my visits are classified as maintenance and are NOT covered by any insurance or Medicare. I further understand that Dr. Burgardt does NOT sign or complete reimbursement forms or respond to requests for information from any third part payer.

YES \_\_\_\_\_ Express Service Begins on the Second Visit

I understand that express service does not apply to my first visit, because Dr. Burgardt needs time to fully evaluate me as a new patient. After my first visit, I will be an established patient and be provided express service. I agree that I am not in a hurry and am okay about waiting on my first visit (average first visit last around 1 hour, established patient visits average 10-30 minutes)  
Dr. Burgardt may be busy but he will do the best he can to minimize waiting.

YES \_\_\_\_\_ Roller Machine/Intersegmental Traction(optional) and Open Room Treatment (required)

I understand each visit includes one complimentary warm-up (5-15 minutes) on the roller/Intersegmental Traction or water massage/hydro therapy table, but only if permitted by my condition. I understand that in order to keep things moving and convenient for everyone, treatment is provided in an OPEN-ROOM environment with other patients often nearby and able to see treatment being performed on the patient or hear discussions.

(Private discussions can always be had in the doctors' personal office; this is recommended if you have any concern of being overheard.)

## ***Informed Consent to Chiropractic Treatment***

**The nature of chiropractic treatment:** The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a “click” or “pop”, such as the noise when a knuckle is “cracked”, and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, roller massage tables, or dry hydrotherapy may also be used.

**Possible Risks:** As with any health care procedure, complications are possible following a chiropractic manipulation. **Complications could include** fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

**Probability of risks occurring:** The risks of complications due to chiropractic treatment have been described as “rare”, about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered “rare”.

**Other treatment options which could be considered** may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

**Risks of remaining untreated:** Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

**Unusual risks:** I have had the following unusual risks of my case explained to me. I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment and hereby give my full consent to treatment.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

WITNESS:

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## Chiropractic Express

### ACKNOWLEDGEMENT OF RECEIPT OF HIPAA PRIVACY PRACTICES NOTICE

I, \_\_\_\_\_, [patient's name] acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Chiropractic Express, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

### FOR OFFICE USE ONLY IF NOTICE NOT PROVIDED TO PATIENT

The Practice has made a good-faith effort to obtain an acknowledgement of \_\_\_\_\_ [patient's name] receipt of our Notice of Privacy Practices. In spite of these efforts, the Practice has been unable to obtain a signed acknowledgement of receipt for the following reasons (check all that apply):

- Patient Unavailable
- Patient Physically Unable
- Patient Unwilling

In an effort to obtain the patient's acknowledgement, the Practice has attempted to provide the patient with a

Notice of Privacy Practices in the following manner (check all that applies):

- Personally       Mail       Phone Follow Up
- Other: \_\_\_\_\_

Signature of Chiropractor: \_\_\_\_\_

Print Name of Chiropractor: \_\_\_\_\_

Date: \_\_\_\_\_