



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 Address: _____

Preferred Contact Method: Call Text Email I consent to appointment reminders and office communication by phone/text/email.

Occupation: _____ Hobbies: _____

Employer (if applicable): _____

Emergency Contact Name: _____ Contact Phone No: _____

Primary Care Physician: _____ Phone Number: _____

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? _____

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: _____

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 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
---	---	---	---	---	---	---	---	---	----

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

Current Symptoms: (Check all that apply)

- Pain
- Numbness
- Tingling
- Weakness
- Stiffness
- Headaches
- Muscle Spasms
- Limited Motion
- Other: _____

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:

I WANT PAIN RELIEF 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.

I WANT PAIN RELIEF AND REGULAR PREVENTATIVE ADJUSTMENTS FOLLOWING PAIN RELIEF.
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.

I certify that the above information is accurate to the best of my knowledge.

Signature: _____ Date: _____



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HEALTH HISTORY & LIFESTYLE

Date: _____

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

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

I certify that the above information is accurate to the best of my knowledge.

Signature: _____ Date: _____



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PRIOR CARE, MEDICATIONS & HISTORY

Date: _____

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

Location on Body & Reason	Date
1.	Date: _____
2.	Date: _____
3.	Date: _____

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

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____

3. LIST CURRENT MEDICATIONS AND THE CONDITION TREATED (Purpose)

Medication / Drug	Condition Treated (Purpose)	Medication / Drug	Condition Treated (Purpose)

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 INFORMATION

Have you ever been advised to have surgery for this condition? Yes No If yes, please explain: _____

Have you ever been hospitalized for any condition? Yes No If yes, please explain: _____

Do you have any pacemaker or implanted medical device? Yes No If yes, please explain: _____

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

Do you have any other medical conditions not listed? Yes No If yes, please list below: _____

I certify that the above information is accurate to the best of my knowledge.

Signature: _____ Date: _____



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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.
- 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

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 treating minor pains, prevention, and maintenance care.

Your first visit includes a consultation and examination. If the examination and your patient 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, understand, and agree to the office policies and financial information listed above.

Signature: _____ Printed Name: _____ Date: _____

CONSENT FOR TEXT / EMAIL COMMUNICATION (Optional)

We may send appointment reminders, scheduling information, and office communications via text and/or email. You may opt out at any time.

- YES, I consent to receive text messages related to my appointments and care.
Mobile Phone: _____ Carrier: _____
- YES, I consent to receive emails related to my appointments and care.
Email Address: _____
- NO, I do not consent to receive text messages or emails.



We will never share your information.

Standard message and data rates may apply.



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INFORMED CONSENT TO CHIROPRACTIC 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

I have read, or 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.

Signature

Print Name

Date

WITNESS (OPTIONAL)

Witness Signature

Print Name

Date



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ACKNOWLEDGEMENT OF PRIVACY POLICY

Date: _____



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 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.*