Chiropractic eXpress

Dr. Craig Burgardt - Chiropractic Physician – License: CH11868
2886 Tamiami Trail, Suite 6
Port Charlotte, FL 33952
(941)-249-9020

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 (??)

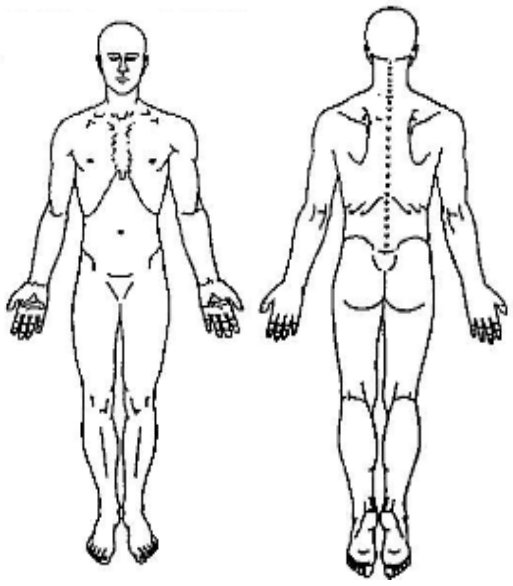
Check One: _____ Pain is Constant or _____Pain comes and goes
Please draw the location of the pain on the figures below. Use an X or circle the affected area(s)

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.



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:

_____

_____

_____

_____

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: $50, then $50 per visit thereafter unless purchasing a visit package, always paid day of treatment. 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 10-20 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 herby 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: _____

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: _____