Welcome To Our Office!

File # ______

Today's Date ____/____/____

Name ______________________________ **Preferred Name**______________________
First *Middle* *Last*

Address____

City______________________ **State**__________ **Zip Code**______________

Mobile Phone______-______-_________ **Home Phone**______-______-_________ **Work Phone**______-______-_________

Email Address______________________________________

Would you like to receive appointment reminders via email and text message? ❑ Yes ❑ No

If yes, who is your cell phone provider? ❑ AT&T ❑ Verizon ❑ U.S. Cellular ❑ Sprint ❑ T-Mobile ❑ Other__________

Date of Birth ____/____/____ **Age**_______ **Gender** ❑ Male ❑ Female

Social Security # _______-_______-_________

Marital Status ❑ Single ❑ Married ❑ Partner ❑ Separated ❑ Widowed

Spouse's Name________________________ **Number of Children/Ages**________________________

Emergency Contact________________________ **Phone #**______-______-_________ **Relationship**______________

Employment Status ❑ Employed ❑ Unemployed ❑ Student ❑ Retired ❑ Stay-at-home

Occupation ________________________ **Employer** ________________________________

How did you hear about us? ❑ Family ❑ Friend ❑ Co-worker ❑ Clinic Website ❑ Google ❑ Social Media ❑ TV

If you were referred by a person may we thank them? ❑ Yes ❑ No **Person's Name**________________________

Were you referred by another physician? ❑ Yes ❑ No **Doctor's Name**________________________

Previous chiropractic care? ❑ Yes ❑ No **Chiropractor's Name**______________________

If yes, for what problem? ______________________________ **Date of Last Adjustment** ____/____/____

Is today's visit due to a work-related injury or auto accident? ❑ Yes ❑ No *(If yes, please see receptionist for additional paperwork)*

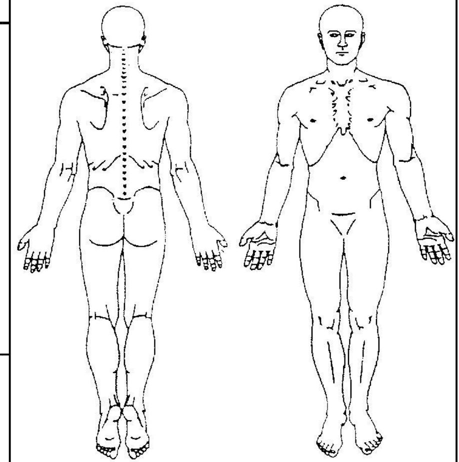
What type of care are you interested in?
❑ Pain Relief ❑ Complete Resolution of Current Condition ❑ Improved Athletic Performance ❑ Healthy Lifestyle/Wellness

BURT CLINIC OF CHIROPRACTIC

Reason For This Visit:

Primary Complaint____

Secondary Complaint____



What level of intensity would you rate your pain?
(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe)

Please select all that apply:

❑ Achy	❑ Burning	❑ Cramping	❑ Deep	❑ Dull
❑ Numbness	❑ Radiating	❑ Sharp	❑ Shooting	❑ Soreness
❑ Stabbing	❑ Stiff	❑ Throbbing	❑ Tightness	❑ Tingling

Frequency of symptoms? ❑ Constant ❑ Frequent ❑ Intermittent ❑ Occasional

When did your symptoms start?_________________________

Was the onset… ❑ Gradual ❑ Sudden

Is your pain… ❑ Increasing ❑ Decreasing ❑ Not Changing ❑ Variable

How did you injure yourself?____

What makes your symptoms worse?____

What makes your symptoms better?____

Have you ever experienced this in the past? ❑ Yes ❑ No_________________________________

How does this affect your personal life? (self care, housework, relationships)_________________

How does this affect your work life? (missed days, inability to lift, stand, sit)_________________

Does this effect your sleep? ❑ Yes ❑ No____

What home remedies have you tried? (ice, heat, stretching, massage)_________________________

Have you seen another doctor or chiropractor for this complaint? ❑ Yes ❑ No_________________

If yes, what tests were done and what treatments were performed? (x-rays, MRI, CT)___________

Have you experienced any of the following symptoms along with this complaint:
❑ Fever/chills ❑ Night sweats ❑ Changes in bowel or bladder function ❑ Unexplained weight loss, fatigue, or blood loss
❑ Dizziness/Vertigo ❑ Visual disturbances ❑ Speech alterations ❑ Weakness in arms or legs

Does this affect any of the following tasks?

❑ Bathing/Showering	❑ Bending Forward	❑ Driving
❑ Brushing Teeth	❑ Bending Left	❑ Golfing
❑ Drying Hair	❑ Bending Right	❑ Exercising
❑ Cleaning	❑ Carrying Objects	❑ Hobbies
❑ Combing Hair	❑ Getting Up From Chair	❑ Home Maintenance
❑ Eating	❑ Kneeling	❑ Household Chores
❑ Getting In/Out of Bend	❑ Leaning Back	❑ Mowing Lawn
❑ Going to Bathroom	❑ Lifting Objects	❑ Picking Up Kids
❑ Doing Laundry	❑ Reaching	❑ Playing Sports
❑ Preparing Meals	❑ Standing	❑ Raking Leaves
❑ Putting on Pants	❑ Stair Stepping	❑ Shoveling Snow
❑ Putting on Shirt	❑ Sitting	❑ Sleeping
❑ Putting on Shoes	❑ Twisting	❑ Swimming
❑ Taking Out Trash	❑ Walking	❑ Yard Work

BURT CLINIC OF CHIROPRACTIC

Patient Specific Functional Scale:

Please list 2 activities that are currently limited because of your symptoms. Rate them on a scale from 0-10. (0 being unable to perform activity and 10 being able to perform activity at same level as before injury)

1.______________________________ Rating (0-10)__________

2.______________________________ Rating (0-10)__________

Past Health History:

Have you ever…

Yes	No	
❑	❑	Had any significant falls, slips, or injuries?______________________
❑	❑	Been knocked unconscious?______________________
❑	❑	Been in a car accident?______________________
❑	❑	Been treated for a spine problem/nerve disorder?______________________
❑	❑	Fractured/broken a bone?______________________
❑	❑	Had surgery?______________________
❑	❑	Been hospitalized for other than surgery?______________________

Please mark any you currently have or have had previously:

- ❑ AIDS
- ❑ Alcoholism
- ❑ Allergies
- ❑ Anemia
- ❑ Arteriosclerosis
- ❑ Arthritis
- ❑ Asthma
- ❑ Back Pain
- ❑ Breast Lump
- ❑ Bronchitis
- ❑ Bruise Easily
- ❑ Cancer
- ❑ Chest Pain/Conditions
- ❑ Cold Extremities
- ❑ Constipation
- ❑ Cramps
- ❑ Depression
- ❑ Diabetes
- ❑ Digestions Problems
- ❑ Dizziness
- ❑ Excessive Menstruation
- ❑ Eye Pain/Difficulties
- ❑ Fatigue
- ❑ Frequent Urination
- ❑ Headache
- ❑ Hemorrhoids
- ❑ High Blood Pressure
- ❑ Hot Flashes
- ❑ Irregular Heart Beat
- ❑ Irregular Cycle
- ❑ Kidney Infection
- ❑ Kidney Stone
- ❑ Loss of Memory
- ❑ Loss of Balance
- ❑ Loss of Smell
- ❑ Loss of Taste
- ❑ Migraine Headache
- ❑ Neck Pain or Stiffness
- ❑ Nervousness
- ❑ Nosebleeds
- ❑ Pacemaker
- ❑ Polio
- ❑ Poor Posture
- ❑ Prostate Issues
- ❑ Ringing in Ears
- ❑ Sciatica
- ❑ Shortness of Breath
- ❑ Sinus Infection
- ❑ Sleep Problems/Insomnia
- ❑ Spinal Curvatures
- ❑ Stroke
- ❑ Swelling in Ankles
- ❑ Swollen Joints
- ❑ Thyroid Condition
- ❑ Tuberculosis
- ❑ Ulcers
- ❑ Varicose Veins
- ❑ __________________
- ❑ __________________
- ❑ __________________

Family History:

Is there a family history of…? *(Grandfather, Grandmother, Mother, Father, etc…)*

- ❑ Heart Disease__________________
- ❑ Cancer__________________
- ❑ Stroke__________________
- ❑ Osteoarthritis__________________
- ❑ Rheumatoid Arthritis__________________
- ❑ Diabetes__________________
- ❑ High Blood Pressure__________________
- ❑ Other__________________

BURT CLINIC OF CHIROPRACTIC

Additional Health Information:

What *non-prescription* drugs are you taking? ❑ None ❑ Tylenol ❑ Advil ❑ Ibuprofen ❑ Aspirin ❑ Excedrin ❑________

What *prescription* drugs are you taking?

❑ Anti-inflammatory ❑ Birth Control ❑ Blood Pressure ❑ Cholesterol Meds ❑ Depression/Anxiety ❑ Diet Pills
❑ Diabetes Meds ❑ Insulin ❑ Muscle Relaxers ❑ Pain Killers ❑ Sleeping Aids ❑ Other

Please list your current medications:

	Medication Name	***Frequency***	***Dosage***	***For What Condition?***
1				
2				
3				
4				
5				

Are you allergic to any certain medications? ❑ Yes ❑ No *If yes, please list:*____________________________________

Do you have allergies? ❑ Yes ❑ No *If yes, please list:*____

What vitamins/supplements are you taking? ❑ None ❑ Multi-vitamin ❑ Fish Oil ❑ Probiotics ❑ Other________________

Do you smoke? ❑ Yes ❑ Former smoker ❑ Never been a smoker
If yes, how often do you smoke: ❑ Current every day smoker ❑ Current sometimes smoker # Packs per day____
If yes, what is your level of interest in quitting smoking? 0 1 2 3 4 5 6 7 8 9 10

Do you consume alcohol? ❑ Yes ❑ No # Drinks per week_________

Do you consume caffeine? ❑ Coffee ❑ Soda ❑ Tea ❑ Energy Drinks # Drinks per day________

Do you exercise? ❑ No ❑ Infrequently ❑ Occasionally ❑ Regular ❑ Avoid due to pain

Women Only: Are you pregnant? ❑ Yes ❑ No ❑ Maybe **Number of Weeks________** **Due Date ____/____/____**

In general, would you say your health right now is… ❑ Excellent ❑ Very Good ❑ Fair ❑ Poor

Health and Wellness Goals:

In the next 4-6 weeks, I'd like to…

____

____

In the next year, I'd like to…

____

BURT CLINIC OF CHIROPRACTIC

Informed Consent:

Medical doctors, chiropractors, osteopaths, and physical therapists who perform manipulation are required by law to obtain your informed consent before starting treatment.

I, ____do hereby give my consent to the performance of conservative non-invasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used. Although spinal and extremity manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

- Soreness/Bruising: I am aware that, like exercise, it is common to experience muscle soreness and occasionally bruising in the first few treatments.

- Dizziness: Temporary symptoms like dizziness and nausea can occur, but are relatively rare.

- Fracture/Joint Injury: I further understand that in isolated cases, underlying physical defects, deformities or pathologies, like weak bones from osteoporosis, may render the patient susceptible to injury. When osteoporosis, degenerative disc, or other abnormality is detected, this office will proceed with extra caution.

- Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in a million to once in ten million treatments. To put these occurrences in perspective, once in a million is about the same chance as getting hit by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

- Physiotherapy Burns: Some of the therapies used in this office generate cold and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase in pain and possible blistering. This should be reported to the doctor.

Tests have been or will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

Treatment Results:
I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits. I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

Alternative Treatments Available:
Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, prescription or over-the-counter medications, exercises, physical therapy and possible surgery.

- Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

- Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.

- Surgery: Surgery may be necessary for joint instability or serious disc rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

- Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely. To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

___________________________________ Signature

____/____/____ Date

BURT CLINIC
OF CHIROPRACTIC

Patient's Rights and Responsibilities

Health care involves a partnership between patients, families, and health care providers, each of whom have certain rights and responsibilities. When you are well-informed, participate in treatment decisions, and communicate openly with your doctor and other health professionals, you help make your care as effective as possible. This clinic encourages respect for the personal preferences and values of each individual. The undersigned hereby acknowledges that I have received, reviewed, and understand my rights and responsibilities.

Initial

Notice of Privacy Practices

Our practice is dedicated to maintain the privacy of your health information according to the guidelines set forth by federal and state law. These laws also require us to provide you with notice of privacy practices, and to inform you of your rights and our obligations concerning your health information. The undersigned hereby acknowledges that I have received, reviewed, and understand and agree to the Notice of Privacy Practices of the Burt Clinic of Chiropractic, 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 Burt Clinic of Chiropractic.

Initial

Release of Protected Health Information

I give my consent to allow the transfer and/or discussion of my protected health information to be released to this office. I understand that as a patient, my health information is confidential, and will be treated as such by this office. I understand that any information collected by this office will be for the benefit of care provided, and will remain confidential between this office and the providing practitioner.

Initial

Financial Policy

Payment is expected at the time of service. Your insurance company can and will be billed, determined by your preference and our current status as in-network or out-of-network with that company. We cannot guarantee your coverage, even if our office attempts to confirm your benefits and eligibility. Final approval of coverage is based on the explanation of benefits after the claim has been filed. Any balance remaining after insurance benefits are obtained is the responsibility of the patient. Any non-covered services are the responsibility of the patient at the rate determined by in-network or out-of network rates as determined by the insurance company's explanation of benefits. If payment is not rendered at the time of service, the patient is expected to remit payment within 30 days of the patient visit. All balances remaining unpaid after 30 days may be turned over to a collection agency. It is the patient's responsibility to understand his/her insurance policy and the intricacies of coverage. Burt Clinic of Chiropractic cannot guarantee exact details at any given time. We are happy to address questions regarding your account at any time. Please direct account questions to our billing administrator.

Initial

Assignment of Benefits

Assignment of benefits is simply authorizing the Burt Clinic of Chiropractic to file charges directly to your insurance company, saving you time and effort of filing claims yourself. The undersigned hereby authorizes the Burt Clinic of Chiropractic to submit my insurance claims to my insurance company. By having my signature on file, I need not sign each claim submitted by their office. I understand that I may withdraw my signature at any time. I also understand that I am ultimately responsible for all charges for which my insurance does not pay.

Initial

______________________________ ____/____/____
Signature Date