Welcome to our office!
Please provide us with the following information for our records.

Date:_____

Name:_____Prefer to be called: _____
Last First Middle

Address:_____

City:_____State:_____Zip:_____

Email:_____

Home Phone:_(____)_____ Work Phone:_(____)_____

Cell Phone:_(____)_____ Fax Number:_(____)_____

Which is the best number to contact you or to leave a message? Home Work Cell

Birth date:_____ Sex: M / F Marital Status: S / M / P / D / W

Occupation:_____Employer:_____

Employer Address/City/State/Zip:_____

In Case of Emergency-Contact: _____

Relationship:_____

Home Phone:_(____)_____Cell/Work Phone:_(____)_____

Referred By:_____

Physician's Name and Address: _____

Richard W. Burg, DC, ART
Chiropractic, Active Release Techniques® and Nutrition

6330 Telegraph Avenue, Oakland, California 94609 Tel: 510.601.6330 Fax: 510.601.6331

Richard W Burg, DC, ART
6330 Telegraph Ave Oakland CA 94609

NAME_____DATE_____

If you have no present complaints or restrictions in your lifestyle and are here for wellness care please check this box: ☐

Present chief complaint(s)

PLEASE CHECK ALL ANSWERS AND FILL IN THE BLANKS WHERE APPROPRIATE. In the space below please describe the present complaint(s) that brought you to this clinic for chiropractic care. The information you provide concerning the past and present symptoms assist your doctor in obtaining an early understanding of your state of health.

1. Present Complaint: _____
_____

2. Please describe the character of your current pain (**YOU MAY CHECK ONE OR MORE ANSWERS**): ☐ Sharp/Stabbing ☐ Sharp/ Dull
☐ Aches ☐ Dull ☐ Soreness ☐ Weakness ☐ Throbbing/Gnawing ☐ Numbness ☐ Shooting ☐ Gripping/Constricting ☐ Burning ☐ Tingling

3. How often are the complaints present? ☐ Constant (76-100%) ☐ Frequent (51-75%) ☐ Occasional (26-50%) ☐ Intermittent (25% or less)

4. How bad is your pain or ache? Please circle a number: 0 1 2 3 4 5 6 7 8 9 10
NO PAIN **UNBEARABLE**

5. Since your problem began the pain is: ☐ Increasing ☐ Decreasing ☐ Not Changing

6. Did your problem begin: ☐ Immediately after a specific accident ☐ Multiple incidents ☐ Gradually developed over time

7. When did your problem begin? (list specific date if possible)_____

8. Describe how your problem began: _____
_____

9. What treatment have you received for this present condition? ☐ None ☐ Therapy from a PT ☐ A back support ☐ Surgery
☐ Spinal injections ☐ Other _____.

10. Were you previously treated for a different occurrence of this same condition? ☐ Yes ☐ No.
If yes by: ☐ Chiropractor ☐ MD ☐ Therapy ☐ Other_____
(**SPECIFY DATES AND TYPE OF TREATMENT)** _____

11. What makes your problem better? ☐ Nothing ☐ Lying down ☐Walking ☐ Standing ☐ Sitting ☐ Movement/ Exercise
☐ Inactivity ☐ Other _____

12. What makes your problem worse? ☐ Nothing ☐ Lying down ☐Walking ☐ Standing ☐ Sitting ☐ Movement/ Exercise
☐ Inactivity ☐ Other _____

13. How would you grade your stress level? ☐ No Stress ☐ Minimal Stress ☐ Moderate stress ☐ Greatly Stressed

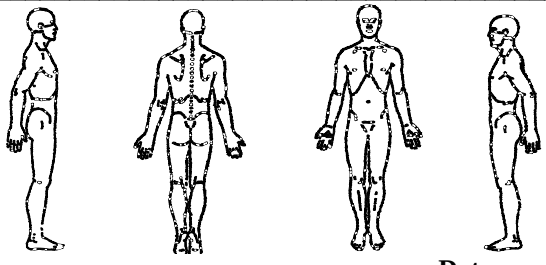
14. Physical activity at work: ☐ Sedentary (More than 50% of Workday) ☐ Light Manual Labor ☐ Manual Labor ☐ Heavy Manual Labor

15. General physical activity: ☐ No Regular Exercise Program ☐ Light Exercise program ☐ Strenuous Exercise Program

16. Are your complaints affecting your ability to work or otherwise be active?
☐ No effect
☐ Some physical restrictions (able to do light duty tasks)
☐ Need limited assistance with common everyday tasks.
☐ Need assistance often
☐ Have a significant inability to function without assistance.
☐ Am totally disabled (impaired) Cannot care for self

Do you want further information/ or have addition questions regarding: _____
What type of doctor do you like to go to? _____

Mark an X on the picture where you have symptoms-including pain, numbness, tingling etc.



Patient's Signature: _____ Date:_____

RICHARD W. BURG, DC, ART
6330 Telegraph Avenue
Oakland, CA. 94609
510-601-6330

6 HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy
☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____
Spinal Exam _____ Chest X-Ray _____ Urine Test _____
Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Chicken Pox	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Rheumatoid Arthritis	☐ Yes	☐ No
Alcoholism	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Measles	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Allergy Shots	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Migraine Headaches	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Miscarriage	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Anorexia	☐ Yes	☐ No	Fractures	☐ Yes	☐ No	Mononucleosis	☐ Yes	☐ No	Suicide Attempt	☐ Yes	☐ No
Appendicitis	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Multiple Sclerosis	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Goiter	☐ Yes	☐ No	Mumps	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Gonorrhea	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Tumors, Growths	☐ Yes	☐ No
Breast Lump	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Parkinson's Disease	☐ Yes	☐ No	Typhoid Fever	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Pinched Nerve	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Bulimia	☐ Yes	☐ No	Hernia	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No	Vaginal Infections	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Herniated Disk	☐ Yes	☐ No	Polio	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Prostate Problem	☐ Yes	☐ No	Whooping Cough	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No	Prosthesis	☐ Yes	☐ No	Other _____		
			Kidney Disease	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No	_____		

EXERCISE
☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY
☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS
☐ Smoking Packs/Day _____
☐ Alcohol Drinks/Week _____
☐ Coffee/Caffeine Drinks Cups/Day _____
☐ High Stress Level Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

7

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
Pharmacy Name _____		
Pharmacy Phone (____) _____		

Richard W. Burg, DC, ART

Chiropractic, Active Release Techniques®, Nutrition

Welcome to 6330 Telegraph Avenue.

The purpose of the following agreements is to help serve you.

Payment of Bills
We request that charges be paid in full at the time of service unless other arrangements are made at the time of service. After your initial office visit, you may pay once at the end of the week if you have multiple appointments in a single week. We will expect you to honor the financial agreements you make with our office. If you find that your circumstances change, advise the doctor/staff immediately. Private insurance companies can be billed (for out of network chiropractic coverage) or we will provide you the necessary documentation to submit a claim to your insurance carrier. We do not represent that you will be reimbursed by your insurance carrier.

Missing or Changing Appointments
If you miss an appointment or cancel (without rescheduling) with less than 24-hour notice, you will be charged for the visit.

Progress Evaluations and Re-Examinations
During the course of your chiropractic care progress evaluations and check-ups will be necessary. Additional time will be allocated and separate fees apply.

For Patients regarding Personal Injury (example: Motor Vehicle Insurance)
Please understand that your insurance policy is an agreement between you and your insurance company. You are financially responsible for all services rendered to you in our office. We are willing to bill your auto insurance carrier directly upon proof of available medical-payment coverage. We will not bill insurance companies for missed appointments. You are personally responsible for missed/cancelled visit charges.

For Patients regarding Worker's Compensation
In order to accept your claim, we must have authorization from your worker's compensation carrier prior to the initial visit. Once authorization is received, we will bill your worker's compensation carrier. We will not bill insurance companies for missed appointments. You are personally responsible for missed/cancelled visit charges.

You agree to pay any and all collection fees for unpaid balances.

I have read the above and I understand and accept these policies.

_____ _____

Patient's Signature Date

Richard W. Burg, D.C.

NOTICE OF PRIVACY PRACTICES

Disclosure of Your Health Care Information

Treatment
We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

Payment
We may disclose your health information to our billing service and your insurance provider for the purpose of payment and/or health care operations.

Workers' Compensation
We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies
We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency.

Public Health
As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings
We may disclose your health information in the course of any administrative or judicial proceeding.

Marketing
We may contact you for marketing purposes or fundraising purposes.
For Example:

> *"As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time and/or in the event that you miss your appointment we will call to re-schedule. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."*
>
> *"It is our practice to participate in charitable events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, the dates and times, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of Richard W. Burg, D.C. fund-raising events."*

Change of Ownership
In the event that our practice is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised that Richard W. Burg, D.C. is not required to agree to the restriction that you requested.

- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

- You have the right to inspect and copy your health information.

- You have a right to request that Richard W. Burg, D.C. amend your protected health information. Please be advised that Richard W. Burg, D.C. is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.

- You have a right to receive an accounting of disclosures of your protected health information made by Richard W. Burg, D.C.

- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices
Richard W. Burg, D.C. reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Richard W. Burg, D.C. is required by law to comply with this Notice.

Richard W. Burg, D.C. is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information.

If you have any questions and/or complaints regarding this notice or if you want more information about your privacy rights, please contact: Dr. Richard Burg by calling the office at 510-601-6330. If Dr. Richard Burg is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.
If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of _____/_____/_____

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Richard W. Burg, D.C. with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

_____
Patient's Name (print)

_____ _____
Patient's Signature Date

_____ _____
Authorized Facility Signature Date

RICHARD W. BURG, DC, ART

Chiropractic Active Release Techniques® Nutrition

Informed Consent

PATIENT NAME: _____

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis/Examination/Treatment

As part of the analysis, examination, and treatment, you are consenting to the following procedures:

___spinal manipulative therapy
___active release techniques (ART)
___range of motion testing
___muscle strength testing
___kinesiotaping
___hot/cold therapy
___palpation
___Other (please explain)

___orthopedic testing
___postural analysis
___basic neurological testing
___dietary supplements
___radiographic studies
___Graston Technique

_____

_____

The material risks inherent in chiropractic adjustment

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing serious complications including stroke.

Complications of ART include local bruising, fainting, temporary pain or discomfort and the possible temporary aggravation of prior existing symptoms. If you receive dietary supplements the risks include, but are not limited to allergic reactions to supplements.

Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibly to inform me.

The probability of those risks occurring

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are

estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you choose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated

Remaining untreated may allow the formation of adhesions and reduce mobility which may set ip a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Richard Burg and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____ **Dated:** _____

_____ _____

Patient's Name **Doctor's Name**

_____ _____

Signature **Signature**

_____

Signature of Parent or Guardian
(if a minor)