BERGMAN FAMILY CHIROPRACTIC

HEALTH & STRESS SURVEY

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www.bergmanchiropractic.com

Date: _____

Account # _____

Name: _____ Phone (home) _____ Cell _____

Address _____ City _____ State _____ Zip _____

Email Address _____ Would like to Receive our Free E-News? ☐ Yes ☐ No

Place of employment _____ Job Title _____

Social Security # _____ Date of Birth _____ Age _____

Are You Married? ☐ Yes ☐ No Do You Have Children? ☐ Yes ☐ No Are They Currently Under Care Here? ☐ Yes ☐ No

Emergency Contact (Relationship) _____ Phone # _____

How were You Referred? _____

Reason For Today's Visit: ☐ New Injury ☐ Old Injury ☐ Chronic Pain ☐ Wellness Visit

Are You In Pain? ☐ Yes ☐ No Discomfort 1 2 3 4 5 6 7 8 9 10 Intense (Please Circle One)

1. **Check off** ☑ any of the following symptoms you have experienced in the past 6 months:

☐ Low back pain	☐ Elbow pain	☐ Tension Across top of shoulders
☐ Dizziness	☐ Shoulder pain	☐ Pain between shoulder blades
☐ Neck pain	☐ Hip pain	☐ Numbness or tingling in arms
☐ Tension Headaches	☐ Knee pain	☐ Numbness or tingling in legs
☐ Tired/Fatigued	☐ Ankle/Foot pain	☐ Difficulty sleeping
☐ Wrist/Hand pain	☐ Ringing in ears	☐ Allergies
☐ Digestive problems	☐ Weight problems	☐ Nervousness

Which of the above is worse? _____

How long have you had it? _____

WOULD YOU LIKE TO GET RID OF THE PROBLEM? ☐ **Yes** ☐ **No**

What medications are you taking? _____

_____

Is there anything else that you want to ask the Doctor? ☐ **Yes** ☐ **No** _____

Bergman Family Chiropractic
TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to obtain it. This will prevent any confusion or disappointment.

Adjustment: The adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxations. Our chiropractic method of correction is by specific adjustments of the spine.

Health: The state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral subluxations: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease. We only offer to diagnose either vertebral subluxations or neuromusculoskeletal conditions. However, if during the course of chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnoses or treatment for those findings, we will recommend that you seek the services of another healthcare provider.

Regardless of what the disease is called, we do not offer to treat it, nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

I,_____have read and fully understand the above statements.
(Please print)

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____
(Sign) *(Date)*

Consent to evaluate and adjust a minor child:

I, _____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and herby grant permission for my child to receive chiropractic care.

PREGNANCY RELEASE:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his associates have my permission to perform an X-ray evaluation. I have been advised that X-ray can be hazardous to an unborn child.

Date of last menstrual cycle. _____ _____ _____
(Sign) *(Date)*

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor or intern, affiliated with Bergman Family Chiropractic.

The nature of the Chiropractic Adjustment: Your Chiropractic doctor or intern may use his hands or a device to manipulate the area being treated. You may feel or hear a "click" or "pop," and you may feel movement. Chiropractic treatment may also include activity advice, exercise, hot or cold packs, electric stimulation or other types of therapy. Your Chiropractic doctor will recommend treatment that is most appropriate for your condition.

Possible Risks: Chiropractic treatment is safe and the majority of patients experience improvement. Approximately 30% of patients experience slight pain in the area, possibly due to minor strain of muscle, tendon, or ligament. When this occurs, the pain is brief and self-limiting over the next few days. Temporary minor pain may also occur with exercise, heat, cold and electric stimulation. Possible skin irritations, burns, fractures, or electrical shocks may occur with thermal or electrical therapy but are rare. Some soft tissue treatments may produce local discomfort, reddening of the skin, and superficial tissue bruising/soreness during and post treatment.

Chiropractic adjustments and stroke risk is so low that the Canadian Medical Association Journal puts the risk at 1 : 5,850,000 to put this in perspective you have a 1 : 6250 chance of being struck by lightning according to the National Weather Service (June 2013). So you have about a thousand times greater risk of getting struck by lightning than having a stroke with a Chiropractic adjustment.

I understand that, in the practice of chiropractic care there are some risks to treatment, I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. By signing below I agree to the above, and allow the doctor or intern, affiliated with Bergman Family Chiropractic to perform such. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ _____

Patient's Name (Please Print) **Date**

_____

Patient or Guardian's Signature