

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

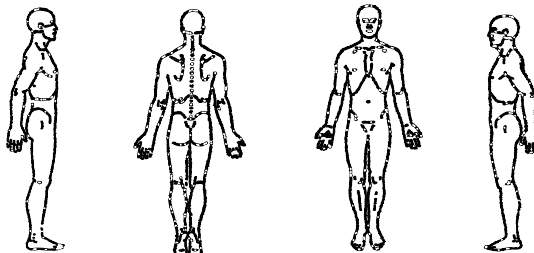
14. Physical activity at work: Sedentary (More than 50% of Workday) Light Manual Labor Manual Labor Heavy Manual Labor

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:** _____

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HEALTH HISTORY

RICHARD W. BURG, DC, ART

6330 Telegraph Avenue

Oakland, CA. 94609

510-601-6330

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

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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, DC, ART 6330 Telegraph Avenue Oakland, CA 94609 510.601.6330

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