Burkhalter Chiropractic & Wellness

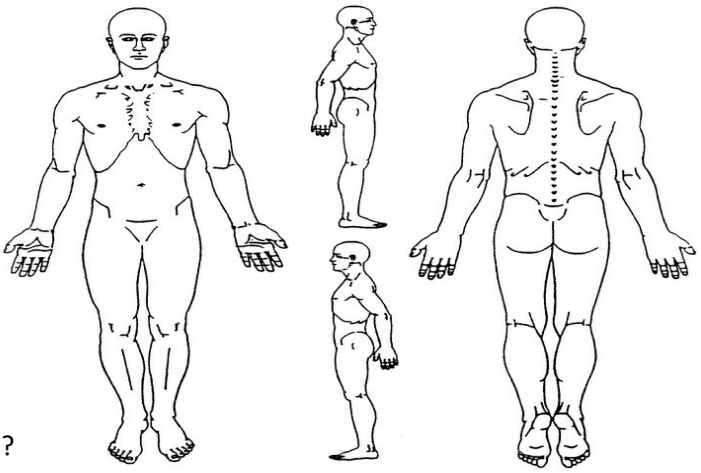
920 8th Avenue Baraboo, WI 53913 608-356-3811
Dr. Ronald J. Burkhalter * Dr. Melanie A. Burkhalter * Dr. Austin J. Burkhalter * Dr. Justin D. Huinker

Patient Intake Form

Patient Name: _____Date: _____
Address: _____City: _____State: _____Zip: _____
Home Phone: _____Cell Phone: _____Work Phone: _____
Date of Birth: _____Age:_____ Email: _____
Male Female (circle one) Single Married Divorced Widowed (circle one)
Emergency Contact Name: _____ Phone: _____Relationship:_____
Whom may we Thank for your referral?_____

Payment for services will be by: Cash/Check/CC _____ Health Ins _____ Auto Ins _____ Worker's Comp_____
Name of Insurance Co: _____ Insured's Employer: _____
Are you covered by more than one Insurance co? No ____ Yes - list name _____

1) Is today's problem caused by: ____ Auto Accident ____ Work Accident ____ Neither
2) Circle on the drawing below where you have pain/symptoms
3) List your complains in order:



1._____
2._____
3._____
4._____
5._____

4) How often do you experience your symptoms?
___ Constantly (76-100% of the time) ___ Frequently (51-75% of the time)
___ Occasionally (26-50% of the time) ___ Intermittently (1-25% of the time)
5) How would you describe the type of pain?
___ Sharp ___ Burning ___ Shooting ___ Tingly ___ Dull ___ Achy ___ Stiff ___ Numb
With motion pain is: ___ Sharp ___Shooting ___ Stabbing ___ Electric like
What time of day is your problem worse? ___ AM ___ Mid-day ___ PM
6) How are your symptoms changing with time?
___ Getting worse ___Staying the same ___ Getting Better
7) Using a scale from 0-10 (10 being the worst), how would you rate your problem?
0 1 2 3 4 5 6 7 8 9 10 (circle one)
8) How much has the problem interfered with your ability to work?
___ Not at all ___ A little bit ___ Moderately ___ Quite a bit ___ Extremely
9) How much has the problem interfered with your social activities?
___ Not at all ___ A little bit ___ Moderately ___ Quite a bit ___ Extremely
10) Who else have you seen for your problem?
___ Chiropractor ___ Neurologist ___ ER Physician ___ Orthopedist ___ Massage Therapist
___ Physical Therapist ___ Primary Care Physician___ No one ___ Other - please list: _____
11) How long have you had the problem? _____

12) How do you think the problem began? _____
13) Do you consider this problem to be severe? ___ Yes ___ Yes, at times ___ No
14) What makes the problem worse: _____
What makes the problem better: _____
15) What concerns you the most about your problem or what does it prevent you from doing?
_____
16) What is your: Height _____ Weight _____ Age _____
Employer: _____ Occupation: _____
17) How would you rate your overall Health? ___Excellent ___Very Good ___Good ___Fair ___Poor
What type of exercise do you do and how often?
Type: _____Times per week? _____
18) Do you have a family physician? Yes No Doctor's name? _____
Date of last physical exam? _____

Family History: (If you are adopted, please check here and skip to the next section ___)

Heart disease Y N If yes, who? _____ Cancer Y N If yes, who? _____
Stroke Y N If yes, who? _____ Diabetes Y N If yes, who? _____
High Blood Pressure Y N If yes, who? _____ Kidney Disease Y N If yes, who? _____
Muscle/Bone/Nerve Disease Y N If yes, who? _____ __
Other Y N If yes, who? _____

Traumas, Surgeries, Hospitalizations:

Have you ever been hospitalized? Y N If yes, explain: _____
_____
Been in an Auto accident? Y N If yes, explain:_____
_____
Had surgery? Y N If yes, explain: _____
_____
Breast Augmentation? Y N
Any other notes: _____
_____

Please list any medications/supplements that you are taking and for what condition (list dosage and amounts).

_____
_____
_____
_____
Are you allergic to any medications?_____
_____

Diet:

☐ I eat fast food, candy, etc. more than 6 times per month.
☐ I occasionally eat fast food, candy, etc. 1-5 times per month.
☐ It is rare for me to eat fast food, candy etc.

Habits:

	Never	Past	Current
Smoking	☐	☐	☐
Packs per day_____			
Drink Alcohol	☐	☐	☐
Recreational Drug Use	☐	☐	☐

Sleep Positions: ____Back ____ Sides ____Stomach

General:	Never	Past	Current
Loss of sleep	☐	☐	☐
Fatigue	☐	☐	☐
Nervousness	☐	☐	☐
Weight Loss/Gain	☐	☐	☐
Allergies	☐	☐	☐
Anemia	☐	☐	☐
Diabetes	☐	☐	☐
Cancer	☐	☐	☐
Type:_____			
Thyroid Disease	☐	☐	☐
Alcoholism	☐	☐	☐
Drug Abuse	☐	☐	☐

Gastrointestinal:			
Change of Appetite	☐	☐	☐
Poor Digestion	☐	☐	☐
Nausea	☐	☐	☐
Pain over Abdomen	☐	☐	☐
Ulcers	☐	☐	☐
Hernia	☐	☐	☐
Liver Problems	☐	☐	☐
Diarrhea	☐	☐	☐
Constipation	☐	☐	☐
Hemorrhoids	☐	☐	☐
Appendicitis	☐	☐	☐
Date: _____			

Genitourinary:			
Frequent Urination	☐	☐	☐
Kidney Disease	☐	☐	☐
Urinary Infection	☐	☐	☐
Inability to Control Urination	☐	☐	☐
Breast Lump or Pain	☐	☐	☐

Ears, Eyes, Throat:			
Pain in eyes	☐	☐	☐
Hearing problems	☐	☐	☐
Ringing in ears	☐	☐	☐
Nosebleeds	☐	☐	☐
Sinus Problems	☐	☐	☐
Tonsillectomy	☐	☐	☐
Date: _____			

Musculoskeletal:			
Neck stiffness/Pain	☐	☐	☐
Low Back Pain	☐	☐	☐
Swollen Joints	☐	☐	☐

Respiratory:	Never	Past	Current
Difficulty Breathing	☐	☐	☐
Chronic cough	☐	☐	☐
Asthma	☐	☐	☐
Pneumonia	☐	☐	☐
Date: _____			
Tuberculosis	☐	☐	☐

Cardiovascular:			
Irregular Heartbeat	☐	☐	☐
High Blood Pressure	☐	☐	☐
Last reading_____/_____			
Pain over Heart	☐	☐	☐
Ankle Swelling	☐	☐	☐
Varicose Veins	☐	☐	☐
Stroke	☐	☐	☐
Date: _____			

Women:			
Painful Periods	☐	☐	☐
Excessive Flow	☐	☐	☐
Irregular Cycle	☐	☐	☐
Hot Flashes	☐	☐	☐
Pregnant	☐	☐	☐
Birth Control	☐	☐	☐
Type_____			

Men:			
Testicular Swelling/Pain	☐	☐	☐
Prostate Problems	☐	☐	☐

Skin :			
Itching	☐	☐	☐
Bruise easily	☐	☐	☐
Changes in Mole(s)	☐	☐	☐
Skin Cancer	☐	☐	☐

Neurologic:			
Weakness	☐	☐	☐
Tremors	☐	☐	☐
Headaches	☐	☐	☐
Fainting	☐	☐	☐
Dizziness	☐	☐	☐
Epilepsy	☐	☐	☐
Numbness/Tingling	☐	☐	☐
Forgetfulness	☐	☐	☐
Depression	☐	☐	☐

Patient Signature_____Date:_____

Informed Consent

Every type of health care is associated with some risks of potential problems. This includes chiropractic health care. We want you to be informed about potential problems associated with chiropractic health care before consenting to treatment. This is a legal requirement in Wisconsin.

Chiropractic adjustments are the moving of bones with the doctor's hands or with the use of a mechanical device or machine (drop table). Frequently adjustments create a "pop" or "click" sound/sensation in the area being treated.

In this office we use trained staff personnel to assist the doctor with portions of your consultation, examination, x-rays, physical therapy application, traction, massage therapy, exercise instruction, etc. Occasionally when your doctor is unavailable, another clinic doctor will treat you on that day.

Neck Artery Dissection and Stoke: *Dissection* is when the lining of the neck artery breaks down. This might happen spontaneously or from a trivial movement (hair shampooing, checking traffic, looking up, etc). Dissections tend to cause neck pain and/or headache. *Dissections* may form a clot that can dislodge and interfere with brain blood flow. If that happens, it is called a *stroke. Stroke* means that a portion of the brain or spinal cord does not receive enough oxygen from the blood stream. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death. The literature is mixed or uncertain as to whether chiropractic adjustments are associated with *stroke* or not. Recent evidence suggests that it is not (2008, 2015, 2016, 2019), although the same evidence suggests that the patient may be entering the chiropractic office for neck pain/headaches or other symptoms that may in fact be a spontaneous *dissection* of a neck artery. There are ***no*** in–the-office tests to diagnose a spontaneous neck artery *dissection* (2020), but they might be detectable with advanced imaging (CT/MRI, etc). If you think you may be suffering from a spontaneous neck artery *dissection* and/or associated *stroke*, you will be immediately referred to emergency services.

Anecdotal cases suggest that chiropractic adjustments may be associated with *dissection* and/or stroke that arise from the vertebral artery; this is because the vertebral artery is located inside the neck vertebrae. The adjustment that is suggested to increase the strain on the vertebral artery is called "extension-rotation-trust atlas adjustment." We do not do this type of adjustment on patients. Other types of neck adjustments may also potentially be related to vertebral artery strokes, but no one is certain. It is estimated that the incidence of this type of complication ranges between 1 per every 400,000 – 10,000,000 neck adjustments (2004). A large 10-year study estimated an incidence of 1 per 5.85 million neck adjustments, equivalent to 1,430 years of clinical practice (2001). If you experience any of the "5 **D**s **A**nd 3 **N**s" (on a following separate page) before, during or after an adjustment, tell us immediately, and if we can't be reached, go to the emergency department immediately.

Two other potential problems that are *not* quantifiable because they are extremely rare and may have no association with chiropractic adjusting are carotid artery injury, and spinal dural leak of cerebral fluid.

Disc Herniations: Both neck and back disc herniations may create pressure on the spinal nerve or on the spinal cord. They are frequently successfully treated by chiropractors and chiropractic adjustments, traction, etc. Occasionally chiropractic treatment (adjustments, traction, etc.) may aggravate a disc/nerve problem and rarely surgery may become necessary for correction.

Cauda Equina Syndrome: Cauda Equina Syndrome occurs when a low back disc problem puts pressure on the nerves that control bowel, bladder, and sexual function. Representative symptoms include leaky bladder, or leaky bowels, or loss of sensation (numbness) around the pelvic sexual organs (saddle area), or the inability to start/stop

a bowel movement. Caudia Equina Syndrome is a medical emergency because the nerves that control these functions can permanently die, and those functions may be lost or compromised forever. The standard approach is to surgically decompress the nerves, and the window to do so may be a short as 12-72 hours, depending. If you have any of these symptoms, tell us immediately, and if we can't be reached, go to the emergency department immediately.

Soft Tissue Injury: Soft tissues primarily refer to muscles and ligaments. Rarely, chiropractic care may overstretch some muscle or ligament fibers. The result is a temporary increase in pain and necessary treatments for resolution, but there are no long-term effects for the patient.

Rib and other Fractures: Rarely a chiropractic adjustment may crack a rib bone, and this is referred to as a fracture. We adjust all patients very carefully, and especially those who have known osteoporosis. Other fracture locations are extremely rare but possible, especially in those aged over 65 years and/or on steroid drugs.

Physical Therapy Burns: Some of the machines we use generate heat. We also use both heat and ice, and recommend them for home care on occasion. Everyone's skin has different sensitivity to these modalities, and rarely, both heat and ice can burn or irritate the skin. The result is a temporary increase in pain, and there may even be some blistering of the skin. Never put an ice pack directly on the skin, always have an insulating towel between. We use *cold (low-level) laser therapy* which produces no heat and cannot result in burn.

Soreness: It is common for chiropractic care to result in temporary increase in soreness in the region being treated. There is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but please do tell your doctor about it.

Other Problems: There may be other problems or complications that might arise from chiropractic treatment other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment.

Chiropractic is a system of heath care delivery, and, therefore, as with any health care delivery system, we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this clinic. We always give you our best care, and if results are not acceptable, we will refer you for additional diagnostic or to another provider whom we feel will assist your situation.

Alternatives to chiropractic care include: do nothing, drugs, surgery, acupuncture, massage, etc. Risks from these procedures should be discussed with that particular provider.

If you have any questions on the above, please ask your doctor. When you have a full understanding, please sign below.

Patient's Name (printed)_____ Date:_____

Patient's Signature:_____

Parent or Guardian's Signature (for minor)_____

Doctor's Signature Verifying Discussion_____ Date:_____

BURKHALTER CHIROPRACTIC, SC

Dr. Ronald J. Burkhalter • Dr. Melanie Arsenault-Burkhalter
920 8th Avenue • Baraboo, WI 53913
Phone (608) 356-3811
Fax (608) 356-8011

FINANCIAL POLICY AGREEMENT

We believe a clear definition of our policies will allow both the patient and doctor to concentrate on the big issue – REGARDING AND MAINTAINING YOUR HEALTH.

1. Cash paying patients are expected to pay at the time of service. Patients' balances may not exceed **$150.00** at any time.

2. All insurance assignment patients must pay their deductible in full and the co-insurance at the time of service. An insured patients' balance may not exceed $200.00 at anytime.

3. Return check fees are $25.00. Balances over 30 days may be subject to additional collection fees and interest charges of 1.5% per month or a late charge of $25.00 per month. All collection fees incurred to collect a balance are due from the patient.

4. In Personal Injury cases the patient is ultimately responsible for all charges incurred. We will submit all charges from services rendered to the respective insurance company and will allow a grace period of no greater than 90 days after the patient is released from the doctor's care.

5. Missed appointments without the courtesy of a 24-hour cancellation notice will be subject to a $30.00 no show charge.

As a service to our patients, we handle all insurance billing and paper work. If you have any questions regarding insurance finances, we will be glad to help answer your questions to the best of our ability. As we do not work for your insurance company, it is recommended that you reach your insurance company personally to ensure your full understanding of your insurance coverage.

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ _____ and assign directly to Burkhalter Chiropractic, Inc. all insurance benefits, if any, otherwise payable to me for service rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient signature: _____ Date _____

Patient's printed name: _____

CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you a copy of our privacy notice, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

Along with this consent form, you will be given a copy of our privacy notice that describes our privacy policies in detail. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke any of your authorizations at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this consent form and a copy of your privacy notice (Notice of Privacy Practices for Protected Health Information).

_____ _____

Printed Name Authorized Provider Representative

_____ _____

Signature Date

_____

Date

WISCONSIN CHIROPRACTIC ASSOCIATION AUTHORIZATION

Your chiropractor and members of the practice staff may need to disclose your name, address, phone number, billing information and your clinical records to the Wisconsin Chiropractic Association (WCA). This disclosure will be made if we need the WCA's assistance to receive reimbursement for your services or, we need the WCA's assistance because the party responsible for reimbursing your services has improperly processed your claim.

By signing this form you are giving us authorization to send the WCA this information. You are also giving the WCA authorization to re-disclose your information to the party responsible for the payment of your services, the WCA's legal counsel, and state or federal agencies that may be asked to intercede on your behalf.

You may restrict the individuals or organizations to whom your health care information is released or revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we received your request to revoke your authorization.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by the person who receives the information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we may send to the WCA at any time. (§164.524).

This notice is effective as of _____. This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

_____ _____

Patient name printed Date

_____ _____

Patient Signature Authorized Provider Representative

_____ _____

Personal representative printed Personal representative signature

_____

Description of personal representative's authority to act for the patient.

APPOINTMENT REMINDERS AND HEALTH CARE INFORMATION AUTHORIZATION

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not available, a message will be left on your answering machine or with the person answering the phone. By signing this form, you are giving us authorization to contact you with these reminders and information and to leave messages on your answering machine or with individuals at your home or place of employment.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time.

This notice is effective as of _____. This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

_____ _____

Patient Name Printed Date

_____ _____

Patient Signature Authorized Provider Representative

_____ _____

Personal Representative Printed Personal Representative Signature

_____

Description of personal representative's authority to act for the patient.