Edina Family CHIROPRACTIC

Restoring Health Naturally

# WELCOME!

We are so glad you're here. Our focus is to help restore normal, healthy function to each of our patients' bodies, hopefully allowing them to live a longer, fuller life. Some people are looking for relief of pain, other people include regular chiropractic care in their weekly regiment to be their "best," while other patients are children who want to be ear infection free. The list of who our patients are, goes on and on. We promise to meet you where you are at and give you the best care we can to support your health needs.

All our best,

Dr. Christopher and Lily Bargmann

We work with many physicians and medical groups in the area.
Please tell us the name of your primary care physician/MD/DO:

_____

Name of clinic / group practice:

_____

Date: _____

# PATIENT INFORMATION

Name: _____ Age: _____ Gender: M F

Home Address: _____ Home Phone: ( ) _____

City, State, Zip: _____ Work Phone: ( ) _____

Email Address: _____ Cell Phone: ( ) _____

Birth Date: ____ / ____ / _____ Social Security #: _____ - ____ - _____ Marital Status: S M D W

Names of Children: _____ Ages: _____

Occupation: _____ Employer Name: _____

Spouse's Name: _____ Work phone: ( ) _____ Cell Phone: ( ) _____

Spouse's Occupation: _____ Spouse's Employer: _____

How were you referred to our office? _____

# PURPOSE OF THIS VISIT

Reason for this visit - main complaint: _____

Is this purpose related to an auto accident / work injury? ❑ Yes ❑ No If so, when: _____

When did this condition begin? ____ / ____ / _____ It began: Gradually Suddenly Progressively over time

What activities aggravate your symptoms? _____

Is there anything that has relieved your symptoms? ❑ Yes ❑ No Describe: _____

Type of pain: Sharp Dull Ache Burn Throb Spasm Numb Tingling Shooting

Does the pain radiate into your: ____ Arm ____ Leg ____ Does not radiate Is this condition getting worse? ❑ Yes ❑ No

How often do you experience these symptoms throughout the day? 100% 75% 50% 25% 10% Only with activity

Does complaint(s) interfere with: ____ Work ____ Sleep ____ Hobbies ____ Daily routine Explain: _____

Have you experienced this condition before? ❑ Yes ❑ No If so, please explain: _____

Who have you seen for this? _____ What did they do? _____

How did you respond? _____

# EXPERIENCE WITH CHIROPRACTIC CARE

Have you ever seen a chiropractor before? ❑ Yes ❑ No Who? _____ When? _____

Reason for visits: _____

How did you respond? _____

Did your previous chiropractor take before and after x-rays? ❑ Yes ❑ No

Do you have good posture? ❑ Yes ❑ No Describe: _____

Are you aware of any poor posture habits? ❑ Yes ❑ No

Explain: _____

Postural/spinal issues can have a familial or hereditary link. Are you aware of any poor posture habits in your spouse or children? ❑ Yes ❑ No

Explain: _____

Have you noticed a problem or abnormality in their posture? ❑ Yes ❑ No Have you noticed postural problems in one or both of your parents? ❑ Yes ❑ No

Explain: _____

Date: _____

# HEALTH LIFESTYLE

Do you exercise? Yes No How often? 1X 2X 3X 4X 5X 6X 7X per week Other: _____

What activities? Running Jogging Weight Training Cycling Yoga Pilates Swimming _____

Do you smoke? Yes No How much? _____

Do you drink alcohol? Yes No How much / week? _____

Do you drink coffee? Yes No How many cups / day? _____

Do you take any supplements (i.e. vitamins, minerals, herbs)? _____

## HEALTH CONDITIONS

Abnormal postural habits or distortions are the result of trauma or stress to the body that have misaligned the vertebrae in your spine. When these vertebrae are twisted from their normal position, they will cause stress to the spinal cord and the delicate nerves that pass between the vertebrae. These misalignments are called subluxations (sub-lux-a-shuns). It has been extensively documented that subluxations, causing stress to your nerves, will weaken and distort the overall structure of your spine. This results in a weakened and distorted posture. Postural distortions can have many serious and adverse affects on your overall health. The most common and detrimental postural distortion is called Forward Head Syndrome (a "hunched forward" posture starting in the neck and progressively moving down your spine weakening the entire body). Please check any health condition you may be experiencing, now or in the past.

## CERVICAL SPINE (NECK):

Postural distortions from subluxations causing Forward Head Syndrome, in your neck will weaken the nerves into your arms, hands and head affecting these parts of your body. Do you experience:

- ❑ Neck pain
- ❑ Pain into your shoulders/arms/hands
- ❑ Numbness/tingling in arms/hands
- ❑ Hearing disturbances
- ❑ Weakness in grip
- ❑ Headaches
- ❑ Dizziness
- ❑ Visual disturbances
- ❑ Coldness in hands
- ❑ Thyroid conditions
- ❑ Sinusitis
- ❑ Allergies/hay fever
- ❑ Recurrent colds or sickness
- ❑ Low energy/fatigue
- ❑ TMJ/pain/clicking

Explain: _____

## THORACIC SPINE (UPPER BACK):

Postural distortions from subluxations (resulting from Forward Head Syndrome) in the upper back will weaken the nerves to the heart and lungs and affect these parts of your body. Do you experience:

- ❑ Heart palpitations
- ❑ Heart murmurs
- ❑ Tachycardia
- ❑ Heart attacks/angina
- ❑ Recurrent lung infections/bronchitis
- ❑ Asthma/wheezing
- ❑ Shortness of breath
- ❑ Pain on deep inspiration/expiration

Explain: _____

## THORACIC SPINE (MID BACK):

Postural distortions from subluxations (resulting from Forward Head Syndrome) in the mid back will weaken the nerves into your ribs/chest and upper digestive tract, and affect these parts of your body. Do you experience:

- ❑ Mid back pain
- ❑ Pain into your ribs/chest
- ❑ Indigestion/heartburn
- ❑ Reflux
- ❑ Nausea
- ❑ Ulcers/gastritis
- ❑ Hypoglycemia
- ❑ Tired/irritable after eating or when you haven't eaten for a while

Explain: _____

## LUMBAR SPINE (LOW BACK):

Postural distortions from subluxations in the low back (resulting from Forward Head Syndrome) will weaken the nerves into your legs/feet and pelvic organs and affect these parts of your body. Do you experience:

- ❑ Pain into your hips/legs/feet
- ❑ Numbness/tingling in your legs/feet
- ❑ Coldness in your legs/feet
- ❑ Muscle cramps in your legs/feet
- ❑ Constipation / diarrhea
- ❑ Weakness/injuries in your hips/knees/ankles
- ❑ Recurrent bladder infections
- ❑ Frequent/difficulty urinating
- ❑ Menstrual irregularities/cramping (females)
- ❑ Sexual dysfunction
- ❑ Low back pain

Explain: _____

Please list any health conditions not mentioned: _____

Please list any medications currently taking and their purpose: _____

Please list all past surgeries: _____

Please list all previous accidents and falls: _____

# TERMS OF ACCEPTANCE

When a person seeks chiropractic and rehabilitation health care and is accepted for such care, it is essential for both parties to be working towards the same objective. As a chiropractic & rehab facility we have one main goal, to detect and correct/reduce the vertebral subluxation complex. It is important that each person understand both the objective and the method that will be used to attain this goal. This will prevent any confusion or disappointment.

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

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

**Vertebral Subluxation:** 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 it's maximum health potential.

We do not offer to diagnose or treat a disease or condition other than vertebral subluxation. Regardless of what a 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 a major interference to the expression of the body's innate wisdom and ability to heal. Our only method is specific adjusting to correct vertebral subluxations combined with rehabilitation procedures.

**NOTE:** It is understood and agreed the amount paid to Edina Family Chiropractic for x-ray, is for examination only and the x-rays will remain the property of this office, being on file where they may be seen at any time while a patient of this office.

# CONSENT TO CARE

I do hereby authorize the doctors of Edina Family Chiropractic to administer such care that is necessary for my particular case. This care may include consultation, examination, spinal adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays or any other procedure that is advisable, and necessary for my health care.

Furthermore, I authorize and agree to allow the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, to work with my spine through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration to allow for normal biomechanical motion and neurological function.

I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges. I further understand that a fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not. I also clearly understand that if I do not follow the doctors specific recommendations at this office that I will not receive the full benefit from the programs offered, and that if I terminate my care prematurely, that all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits be directed to the doctor for all services rendered. I also understand any sum of money paid under assignment by any insurance company shall be credited to my account, and I shall be personally liable for any and all of the unpaid balance to the doctor.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests. The doctor will not be held responsible for any health conditions or diagnoses that are preexisting, given by another health care practitioner, or are not related to the spinal structural conditions treated at this clinic.

I, _____ , have read or have had read to me, the above consent. I have also had the opportunity to ask questions about this consent, and by signing below I agree to the care. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition for which I seek treatment.

Signature _____ Date _____

If patient is under 18, parent or guardian please sign below:

Signature _____ Date _____

Dr. Christopher Bargmann
Edina Family Chiropractic

# INSURANCE INFORMATION

I clearly understand that all insurance coverage is an arrangement between my insurance carrier and me. If this office chooses to bill any services to my insurance carrier that they are performing these services strictly as a convenience for me. The doctors office will provide any necessary report or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny any claim and that I am ultimately held responsible for any unpaid balances. Any monies received will be credited to my account. I certify that this office visit is not related to any personal injury or worker's compensation case that is active or that has not been closed and finalized.

Signature _____ Date _____

If you would like us to verify insurance and/or benefits for you, please give us a copy of your insurance card.

Dr. Christopher Bargmann
Edina Family Chiropractic