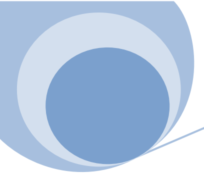


ProActive Chiropractic

Dr. Nate Burdash is a graduate of Northwestern College of chiropractic and has additional education and training /certifications in acupuncture, wellness coaching, bio-meridian analysis, cold laser therapy, auto injuries evaluations and muscle testing for the purpose of supplement prescriptions and neurological evaluations with the use of thermographs, surface EMG and digital range of motion evaluations.

ProActive Chiropractic is a “fee for service” practice and payment is due at the time of service. We accept cash, checks, Visa, MasterCard, American Express and FSA/FLEX accounts/Health Savings Accounts. If you have insurance, we do accept most insurances and are a preferred provider for many and will bill your insurance directly for you. We must explain that your insurance is a contract between you, your employer and the insurance company, but we will try to verify your benefits for you ahead of time. We are not a party to that contract except for our commitment as a contracted provider. So you are liable for your bills directly with our clinic whether payment is made by your insurance or not. If we submit bills to insurance they should pay us directly.

Your initial visits will include an initial consultation followed by an health assessment which may include, chiropractic examination, orthopedic examination, neurological examination, acupuncture meridian testing, QRA Kinesiological testing and other neuromuscular examinations. No x-rays will be taken.

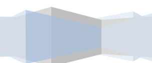
The first visit may last approximately 45 minutes for chiropractic analysis with a second visit report of finding approximately 30 minutes ($100); acupuncture examination approximately 45 minutes ($60) and nutritional examinations only approximately 45 minutes ($50).

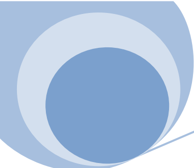
When you schedule an appointment for wellness evaluation, the time is set aside for you. If you need to cancel or reschedule your appointment, please give us a minimum of 24 hour notice. We reserve the right to charge for missed appointments.

Important Note: Please do not consume any nutritional supplements, pain killers, or muscle relaxors the day of your appointment. We also ask that you any medications and/or nutritional supplements (vitamins, herbs, oils,etc.) you are currently taking.

Telephone Consultation and Emergencies: I understand that if I have any questions or new symptoms between scheduled visits, or if an emergency arises, or if I would just like to speak personally to Dr. Burdash I can call the office at no charge.

Thank you for choosing ProActive Chiropractic for your wellness needs.





Informed consent

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records.

The patient understands and agrees to allow this chiropractic office to use their PHI for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment. The patient has the right to examine and obtain a copy of his or her own health records at anytime and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, our office has the right to refuse to give care.

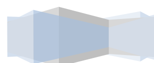
When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

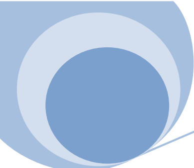
Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity. One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic. Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included. If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

________________________________	___________________________________	________________
Print Name	Signature	Date

Consent to evaluate and adjust a minor child: I, ___________________________ being the parent or legal guardian of ______________________________ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.





New Patient Evaluation

Please complete the following questions carefully. This information will help us to build a personalized wellness program for you. Information you provide is strictly confidential.

DO NOT TAKE ANY NUTRITIONAL SUPPLEMENTS ON THE DAY OF YOUR EXAM

Initial visit date and time: ___________________ Referred by: _________________________

Name: ______________________________ Birth date: _____/_____/_____ Age: ______ M F

Address: ___________________________City: _________________State: ___ Zip: _________

Phone (circle preferred contact):

Home_________________Work___________________Cell__________________

Email: _______________________________________ Do you have Medicare benefits? Y N

Marital Status: Single Married Divorced Widowed No. of Children: ___________________

Occupation: ____

Is today's problem caused by: □ Auto Accident □ Workman's Compensation

1. Please list the current health conditions/symptoms that concern you and rate their severity on a scale from (1 to 10) 10 being the most severe.

____
____
____
____

2. What treatments have you tried for these conditions and has anything helped?

____
____
____

3. What are your hopes and goals for your health in the next 6-12 months?

____
____

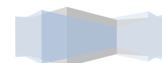
---

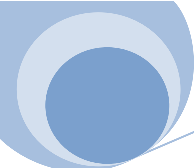
4. **Nutritional Supplements** Please list any nutritional supplements/products you are *currently* using.

____
____

5. **Stress** Please rate your current stress level on a scale of (1 to 10) 10 being the highest

stress:__________





Please list the 5 most stressful events in your life, from the most recent to the most distant. Are any of these situations continuing to impact your life or your health?

a. ____

b. ____

c. ____

d. ____

e. ____

What step(s) are you taking to reduce your stress level?

---

6. **Sleep**
How is your sleep? (check all that apply)
I sleep very well Restless Difficulty falling asleep Difficulty staying asleep
Bad dreams I wake feeling rested I wake feeling tired Other:________________________
How many times per night do you wake up? _________________
What time do you usually go to sleep? ______________________
How many hours of sleep do you get per night? _______________
How many times per night do you wake to urinate? ____________

7. **Exercise**
What kind of exercise do you enjoy on a frequent basis?

____
____
____

How often? ___________________________________ For how long at a time? _____________

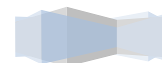
Related to chief concern (pain and symptoms)

8. How often do you experience your symptoms?

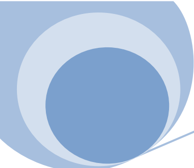
□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

9. How would you describe the type of pain?

□ Sharp □ Numb
□ Dull □ Tingly
□ Diffuse □ Sharp with motion
□ Achy □ Shooting with motion
□ Burning □ Stabbing with motion
□ Shooting □ Electric like with motion
□ Stiff □ Other:___________________



10. How are your symptoms changing with time?
□ Getting Worse □ Staying the Same □ Getting Better



11. 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 (*Please circle*)

12. How much has the problem interfered with your work?
□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

13. How much has the problem interfered with your social activities?
□ Not at all □ A little bit □ Moderately Quite a bit □ Extremely

14. Who else have you seen for your problem?
□ Chiropractor □ Neurologist □ Primary Care Physician
□ ER physician □ Orthopedist □ Other:_____________
□ Massage Therapist □ Physical Therapist □ No one

15. How long have you had this problem? ___________

16. How do you think your problem began?

____

17. Do you consider this problem to be severe?
□ Yes □ Yes, at times □ No

18. What aggravates your problem?

____

19. What concerns you the most about your problem; what does it prevent you from doing?

____

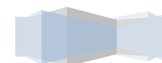
20. What is your: Height___________ **Weight** ____________ **Date of Birth** ___________

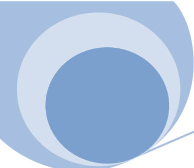
21Occupation ____

22. How would you rate your overall Health?
□ Excellent □ Very Good □ Good □ Fair □ Poor

23. What type of exercise do you do?
□ Stenuous □ Moderate □ Light □ None

24. Indicate if you have any immediate family members with any of the following:
□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ ALS





25. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past Present

Muscular-Skeletal

- □ □ Headaches
- □ □ Neck Pain
- □ □ Upper Back Pain
- □ □ Mid Back Pain
- □ □ Low Back Pain
- □ □ Shoulder Pain
- □ □ Elbow/Upper Arm Pain
- □ □ Wrist Pain
- □ □ Hand Pain
- □ □ Hip Pain
- □ □ Upper Leg Pain
- □ □ Knee Pain
- □ □ Ankle/Foot Pain
- □ □ Jaw Pain
- □ □ Joint Pain/Stiffness
- □ □ Arthritis
- □ □ Hepatitis
- □ □ Pregnancy
- □ □ Rheumatoid Arthritis
- □ □ Cancer
- □ □ General Fatigue
- □ □ Tumor
- □ □ Weak muscles
- □ □ Walking problems
- □ □ Stiff joints
- □ □ Sore muscles

Past Present

Cardio-Vascular-Respiratory

- □ □ Asthma
- □ □ Chronic Sinusitis
- □ □ High Blood Pressure
- □ □ Heart Attack
- □ □ Chest Pains
- □ □ Stroke
- □ □ Angina
- □ □ difficulty breathing
- □ □ persistent cough
- □ □ cough phlegm
- □ □ Rapid heartbeat
- □ □ low blood pressure
- □ □ Varicose veins
- □ □ high cholesterol
- □ □ Heart problems

Urinary System

- □ □ Kidney stones
- □ □ Kidney disorders
- □ □ Bladder infectionis
- □ □ painful urination
- □ □ loss of bladder control
- □ □ Prostate problems
- □ □ Excessive Thirst
- □ □ Frequent Urination

Past Present

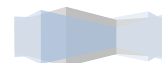
Gastro-Intestinal system

- □ □ Abnormal Weight Gain/Loss
- □ □ Ankle/Foot Pain
- □ □ Abdominal Pain
- □ □ Ulcer
- □ □ Hepatitis
- □ □ Liver/Gall Bladder Disorder
- □ □ Cancer
- □ □ General Fatigue
- □ □ poor appetite
- □ □ excessive hunger
- □ □ Difficulty chewing
- □ □ Difficulty swallowing
- □ □ Excessive thirst
- □ □ nausea
- □ □ Vomiting food
- □ □ Abdominal pain
- □ □ Diarrhea
- □ □ Constipation
- □ □ Black stools
- □ □ Bloody stools
- □ □Hemorrhoids
- □ □ Heartburn

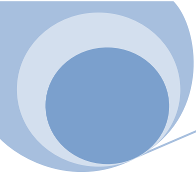
Nervous System

- □ □ numbness
- □ □ loss of feeling
- □ □ dizziness
- □ □ Fainting
- □ □ Headaches
- □ □ Muscle jerking
- □ □ Forgetfulness
- □ □ Confusion
- □ □ Depression

26.How many bowel movements do you average per day? ____________



27. Medications Please list any medications you are currently taking and how long you have taken them



(including birth control pills, aspirin, pain medication, sleep aids, etc.)

_____________________________________ _____________________________________

_____________________________________ _____________________________________

_____________________________________ _____________________________________

_____________________________________ _____________________________________

28. List all of the over-the-counter medications you are currently taking:

____

29. Surgeries

Have you ever had full-body anesthesia (wisdom teeth, to remove tonsils, etc.)? Y / N
Do you have breast implants? Y / N Other surgical implants or prostheses? Y / N
Have you had elective surgery (tummy tuck, face-lift, mole removal, etc)? Y / N
Do you have any internal metal or plastic (such as pins, clamps, plates, etc)? Y / N
Do you have body piercings or tattoos? Y / N
Explain:____

____

30. What activities do you do at work?

□ **Sit:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Stand:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Computer work:**	□ Most of the day	□ Half the day	□ A little of the day
□ **On the phone:**	□ Most of the day	□ Half of the day	□ A little of the day

31. What activities do you do outside of work?

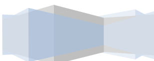
____

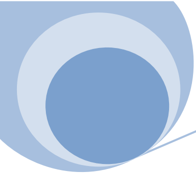
32. Have you ever been hospitalized? □ No □ Yes

if yes, why ____

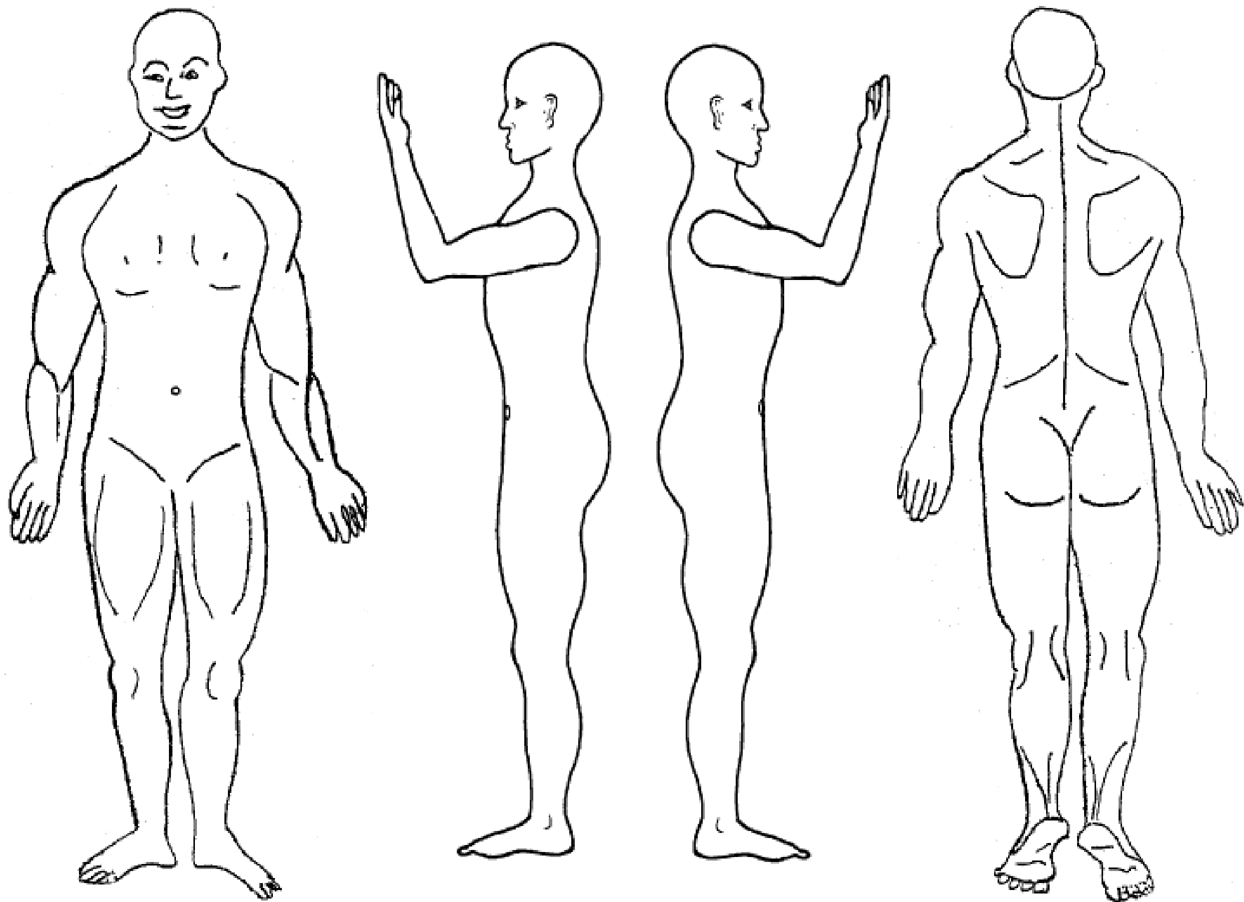
33. Have you had significant past trauma? □ No □ Yes

34. Anything else pertinent to your visit today?_____________________________________





Pain/Scar/Trauma Chart



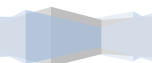
Directions

All Scars. Please draw a red line on the drawing where you have scars, even if they are very old.
Don't forget C-sections, vaccination scars, episiotomies, surgeries, earring puncture holes, tattoos,
facelift scars, vasectomies, etc.

All Trauma Areas. Please put a red "X" where you have had trauma even if it is very old. Don't forget
previous sprains, burns, falls, whiplash (from auto accidents), radiation, etc.

Internal Metal: Please draw a circle on the drawing if you have any type of internal metal objects,
such a surgical steel pin, metal plate, hip replacement, surgical wire mesh, etc.

Date of injury and type of injury. Draw a line from each of the above injury areas and print thetype of injury and approximate date of injury. (For example, draw a line from a shoulder trauma area and print "car accident, 1988")



ProActive Chiropractic |
101 E 5th St. Suite 227 St. Paul, MN 55101
651 778 0080
www.proactivechiropractic.org