Advanced Chiropractic Health & Awareness Center, LLC.
Lakeview Medical Plaza
700 2nd Ave N. # 203
Naples, FL 34102
Ph. 239-315-4694

PATIENT NAME: ______________________________

WELCOME

The doctor and staff of **Advanced Chiropractic Health & Awareness Center, LLC** welcome you and want to provide you with the best possible care. We will conduct a thorough history and physical examination to decide if we can assist you. If we do not believe that your condition will respond to chiropractic care, we will not accept you as a patient but will refer you to another health care provider, if appropriate.

INSURANCE

This office will process your insurance forms upon request. We will do our utmost to provide sufficient information to your carrier to obtain payment for your treatment. We have found that, in some instances, however, insurance companies will deny or reduce payment (i.e. new patient office visit and therapies) despite our best efforts to demonstrate the necessity for care. In the event that full payment is not made for any reason, you must understand that you are responsible to make payment in full.

PATIENT IDENTIFICATION

____
Name

Name or Nickname I prefer to be called in this office ______________________

____
Street

Telephone (Home) ______________________

(Cell) ______________________

____
City, State and Zip

(Work) ______________________
Ok to call there? Yes ( ) No ( )

____
Email address:

____
Occupation

Male ( ) Female ( )

______________________ __________
Date of Birth Age

Contact in case of emergency:

Name: ______________________________ Telephone # ______________________

Name of Parent of Minor Patient (If applicable) ______________________________

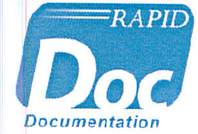
ACCEPTANCE AS PATIENT

I understand and agree that the doctors of **Advanced Chiropractic Health & Awareness Center, LLC** have the right to refuse to accept me as a patient at any time before treatment begins. The taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process if information gathering so that the doctor can determine whether to accept me as a patient.

____
Date

____
Signature

INITIAL EVALUATION – Non Accident Related



LAST NAME: ____________________ FIRST NAME: ____________________ MI: ____ Date: ____________________

What brings you into our office? ☒ **Not accident related**

Do you feel your condition is: ☐ Improving ☐ Staying the same ☐ Getting worse

Have you lost time from work? ☐ Yes ☐ No

Can you perform physical work activities? ☐ Yes ☐ No

If no, because of: ☐ Pain ☐ Weakness ☐ Stress

Can you go to sleep without problems? ☐ Yes ☐ No

Do you awaken because of pain? ☐ Yes ☐ No

Did you have sleep problems before? ☐ Yes ☐ No

Activities of Daily Living Please select all activities which you are currently experiencing problems:

☐ Seeing	☐ Tasting	☐ Smelling	☐ Eating	☐ Hearing	☐ Insomnia
☐ Dressing	☐ Reading	☐ Typing	☐ Writing	☐ Grasping	☐ Using the toilet
☐ Standing	☐ Leaning	☐ Walking	☐ Stooping	☐ Squatting	☐ Loss of sexual drive
☐ Bending	☐ Twisting	☐ Carrying	☐ Lifting	☐ Pushing	☐ Restful sleeping
☐ Sitting	☐ Driving	☐ Sports	☐ Exercising	☐ Reclining	☐ Loss of concentration
☐ Irritable	☐ Riding in car	☐ Air travel	☐ Climbing	☐ Pulling	☐ Changes in personality
☐ Grooming	☐ Pinching	☐ Kneeling	☐ Reaching	☐ Nervous	☐ Tactile feeling
☐ Bathing	☐ Holding				

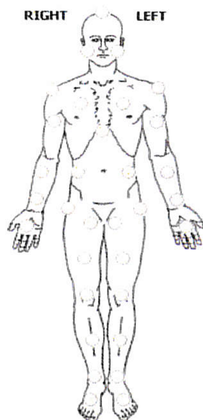
RAPID Doc Documentation

COMPLAINT
(Initial Exam, Daily Note, Follow Up/Final Exam)

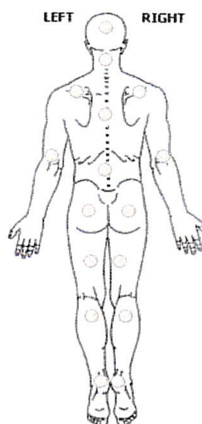
Complaint #__ -

Please place an X on one part of the body where you are experiencing pain or discomfort and list your complaints in the order of severity. (If you do not see your complaint on the picture, please list the complaint on the ***Other*** *line.*

Please grade pain 0-10 (10 is the highest) ⓿ ❶ ❷ ❸ ❹ ❺ ❻ ❼ ❽ ❾ ❿



Other: ____________



This complaint came on:	□ Gradually	□ Immediately	
It is getting:	□ Improving	□ Staying the same	□ Getting Worse
The intensity of this complaint is:	□ Minimal □ Slight	□ Moderate	□ Severe
The frequency of this complaint is: □Intermittent	□ Occasional	□ Frequent	□ Constant
The pain is:	□ Dull	□ Sharp	□ Aching
	□ Shooting	□ Spasm	□ Throbbing
	□ Burning	□ Spasm	□ Tingling
The pain is located on:	□ Left side	□ Right side	□ Both sides

Actions effecting this complaint:

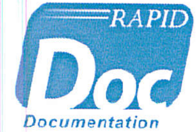
Morning	□ Brings On	□ Aggravates	□ Relieves
Afternoon	□ Brings On	□ Aggravates	□ Relieves
Cold	□ Brings On	□ Aggravates	□ Relieves
Heat	□ Brings On	□ Aggravates	□ Relieves
Medication	□ Brings On	□ Aggravates	□ Relieves
Resting	□ Brings On	□ Aggravates	□ Relieves
Straining	□ Brings On	□ Aggravates	□ Relieves
Standing	□ Brings On	□ Aggravates	□ Relieves
Sitting	□ Brings On	□ Aggravates	□ Relieves
Lying down	□ Brings On	□ Aggravates	□ Relieves
Bending forward	□ Brings On	□ Aggravates	□ Relieves
Bending back	□ Brings On	□ Aggravates	□ Relieves
Bending left	□ Brings On	□ Aggravates	□ Relieves
Twisting left	□ Brings On	□ Aggravates	□ Relieves
Twisting right	□ Brings On	□ Aggravates	□ Relieves
Lifting	□ Brings On	□ Aggravates	□ Relieves
Coughing	□ Brings On	□ Aggravates	□ Relieves
Sneezing	□ Brings On	□ Aggravates	□ Relieves

INITIAL EVALUATION – Non Accident Related

Past Medical History

Please select all conditions that you have had or are currently having:

- ☐ None
- ☐ Other
- ☐ Abdominal pain
- ☐ Weight gain/loss
- ☐ Angina
- ☐ Anorexia
- ☐ Anxiety
- ☐ Aortic aneurysm
- ☐ Arthritis
- ☐ Asthma
- ☐ Bladder infection
- ☐ Blood disorder
- ☐ Breast lumps
- ☐ Breast soreness
- ☐ Bronchitis
- ☐ Cancer
- ☐ Cardiovascular Dx
- ☐Chest pain
- ☐Chronic cough
- ☐ Chronic sinusitis
- ☐ Colitis
- ☐ Constipation
- ☐ Convulsions
- ☐COPD
- ☐ Depression
- ☐ Dermatitis, Eczema/Rash
- ☐ Diabetes
- ☐ Difficulty in swallowing
- ☐ Dizziness
- ☐ Emphysema
- ☐ Endometriosis
- ☐ Epilepsy
- ☐Excessive thirst
- ☐Fainting
- ☐ Frequent urination
- ☐ General fatigue
- ☐ Gout
- ☐ Hand pain
- ☐ Headache
- ☐ Heart attack
- ☐ Heart disease
- ☐ Heartburn/Indigestion
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High cholesterol
- ☐ High PSA
- ☐ High triglycerides
- ☐ Hypertension
- ☐ Irregular menstrual flow
- ☐ Irritable colon
- ☐ Jaw pain
- ☐ Kidney disorders
- ☐ Kidney stones
- ☐ Liver / Gallbladder Problems
- ☐ Loss of appetite
- ☐ Loss of bladder control
- ☐ Low back pain
- ☐ Lung disease
- ☐ Mental Disease
- ☐ Mid back pain
- ☐ Muscular in coordination
- ☐ Neck pain
- ☐ Osteoarthritis
- ☐ Pain in ankle or foot
- ☐ Pain in lower leg or knee
- ☐ Pain in upper arm or elbow
- ☐ Pain in upper leg and hip
- ☐ Painful urination
- ☐ PMS
- ☐ Pneumonia
- ☐ Profuse menstrual flow
- ☐ Prostate problems
- ☐ Rapid heartbeat
- ☐ Renal disease
- ☐Rheumatiod arthritis
- ☐Scoliosis
- ☐Shoulder pain
- ☐Stroke
- ☐ Swelling/stiffness joints
- ☐Thyroid disease of
- ☐Tinnitus/ ear noises
- ☐ Tuberculosis
- ☐ Tumor
- ☐ Ulcer
- ☐ Visual disturbances
- ☐Wrist pain



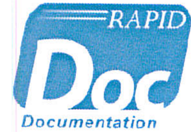
INITIAL EVALUATION – Non Accident Related

Family History

Please select all conditions that run in your family:

□ None	□ Other	□ Abdominal pain	□ Weight Gain/loss	□ Angina
□ Anorexia	□ Anxiety	□ Aortic aneurysm	□ Arthritis	□ Asthma
□ Bladder infection	□ Blood disorder	□ Breast lumps	□ Breast soreness	□ Bronchitis
□ Cancer	□ Cardiovascular Dx	□ Chest pain	□ Chronic cough	□ Chronic Sinusitis
□ Colitis	□ Constipation	□ Convulsions	□ COPD	□ Depression
□ Dermatitis, Eczema/Rash	□ Diabetes	□ Difficulty swallowing	□ Dizziness	□ Emphysema
□ Endometriosis	□ Epilepsy	□ Excessive thirst	□ Fainting	□ Frequent urination
□ General fatigue	□ Gout	□ Hand pain	□ Headache	□ Heart attack
□ Heart disease	□ Heartburn/Indigestion	□ Hepatitis	□ HBP	□ High cholesterol
□ High PSA	□ High triglycerides	□ Hypertension	□ Irregular menstrual flow	□ Irritable colon
□ Jaw pain	□ Kidney disorders	□ Kidney stones	□Liver/Gallbladder problems	□ Loss of appetite
□ Loss of bladder control	□ Low back pain	□ Lung disease	□ Mental disease	□ Mid back pain
□ Muscular coordination	□ Neck pain	□ Osteoarthritis	□ Pain in ankle or foot	□ Pain in lower leg or knee
□ Pain in upper arm or elbow	□ Pain in upper leg and hip	□ Painful urination	□ PMS	□ Pneumonia
□ Profuse menstrual flow	□ Prostate problems	□ Rapid heartbeat	□ Renal Dx	□ Rheumatoid arthritis
□Scoliosis	□Shoulder pain	□Stroke	□ Swelling/stiffness of joints	□ Thyroid disease
□ Tinnitus/ ear noises	□ Tuberculosis	□ Tumor	□ Ulcer	□ Visual disturbances
□ Wrist pain				

INITIAL EVALUATION – Non Accident Related



Surgical History Please select all surgeries that you have had in the past.

☐ None	☐ Other	☐ Abdominal Exploration	☐ Abdominoplasty	☐ Abortion
☐ ACL Reconstruction	☐ Adenoid Removal	☐ Angioplasty	☐ Appendectomy	☐ Bone Fracture Repair
☐ Breast Lump Removal	☐ Bunion Removal	☐ Carotid Artery Surgery	☐ Cataract Surgery	☐ Cervical Spine Surgery
☐ Cholecystectomy	☐ Cosmetic Breast Surgery	☐ C-Section	☐ Facelift	☐ Gallbladder Removal
☐ Gastric Bypass	☐ Heart Bypass Surgery	☐ Heart Surgery	☐ Hemorrhoid Surgery	☐ Hernia Repair
☐ Hip Joint Replacement	☐ Hysterectomy	☐ Kidney Transplant	☐ Knee Arthroscopy	☐ Knee Joint Replacement
☐ Knee Surgery	☐ LASIK Eye Surgery	☐ Liposuction	☐ Lumbar Spine Surgery	☐ Mastectomy
☐ Prostate Removal	☐ Rotator Cuff Surgery	☐ TMJ Surgery	☐ Tonsillectomy	☐ Vasectomy

☐ Surgical History was reviewed:
Not contributory

* **Medications** Please select all medications that you are currently taking:

☐ None	☐ Other	☐ Analgesics	☐ Antacids	☐ Antibiotics
☐ Antihistamines	☐ Anti-Inflammatory	☐ Arthritis	☐ Aspirin	☐ Birth Control
☐ Blood Pressure	☐ Bone Density	☐ Cancer	☐ Cholesterol	☐ Daily Vitamins
☐ Diabetes	☐ Digestion	☐ Heart	☐ Muscle Relaxers	
☐ OTC	☐ Pain	☐ Steroids	☐ Thyroid	

Allergies Please select all items that you are allergic to:

☐ None	☐ Other	☐ Chemical	☐ Environmental
☐ Food	☐ Medication	☐ Seasonal	

Social History Please answer the following questions:

☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Do you have any children? ☐ Yes ☐ No If yes, how many? ______

Do you use: ☐ Tobacco ☐ Alcohol ☐ Coffee

If applicable:
* Please provide a current list of medication and dosage upon arrival. Thank you

Assignment of Benefits Form

Financial Responsibility

I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible for services provided. I hereby agree that all charges connected with the services which are not covered by any insurance program or other third party coverage is due and payable at the time of service. I understand that by signing this form that I am accepting financial responsibility for all payment for medical services and/or supplies received.

Authorization

I hereby irrevocably instruct and direct Insurance Company to pay by check made out and mailed to:

Advanced Chiropractic Health & Awareness Center, LLC.
700 2nd Ave. N. Suite 203
Naples, FL 34102
239-315-4694

If my current policy prohibits direct payment to Provider. I hereby also instruct and direct you to make out the check to me and mail it to the temporary address as follow:

____________________________________ (patient name)
Advanced Chiropractic Health & Awareness Center, LLC.
700 2nd Ave. N. Suite 203
Naples, FL 34102

For the professional or medical expense benefits, allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignees, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance program.

I authorize the provider to deposit checks received on my account when they are made payable to me.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize the provider to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

A photocopy of the Assignment shall be considered as effective and valid as the original.

Dated on this _____ day of ___________________ (month), 20____.

____	______/______/______	____________________
Patient Signature	Date of Birth	SS#

Advanced Chiropractic Health & Awareness Center, LLC.

Dr. Matthew Bergtold
700 2nd Ave N. # 203
Naples, FL 34102
Ph. 239-315-4694

Informed Consent for Chiropractic Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays by Dr. Matthew Bergtold D.C./Advanced Chiropractic Health & Awareness Center, LLC. This consent is extended to other licensed chiropractic physicians, chiropractic assistants or licensed massage therapists who now or in the future, are employed by, working or associated with this office.

While Dr. Matthew Bergtold believes this recommended therapy to be reasonable and medically necessary and the anticipated benefits far outweigh the risks, some patients wonder what complications might occur. Therefore, Dr. Matthew Bergtold believes you should be made aware of these risks before treatment.

For the vast majority of patients, there are few, if any risks; and most of the risks are minimal, such as soreness.

As with any health care procedures, there are certain complications, which may arise during chiropractic treatments. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical Myelopathy and Costovertebral strains and separations. Some types of manipulations of the neck have been associated with injured to the arteries in the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. While none of these complications has ever occurred in our office, should they occur in your case, for your protection, you would be referred immediately to another physician for treatment or the closest ER.

I have the right to discuss the nature, purpose and risks of chiropractic treatments and other recommended procedures. I also understand that specific results are not guaranteed. This consent is designed to inform rather than frighten you. Thus, if you have any questions, Dr. Bergtold will be glad to discuss them with you before beginning treatment.

I have read, or have had read to me, the above consent and explanation of chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to this and future treatments. I intend for this consent to cover the entire course of my treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

SIGN ONLY AFTER YOU UNDERSTAND AND AGREE TO THE ABOVE:

Patient name of Patient: ______________________________

Signature of Patient: ______________________________ Date: __________

Signature of Representative/Guardian (if minor or handicapped): ______________________________

Witness Signature: ______________________________ Date: __________

Advanced Chiropractic Health & Awareness Center, LLC
Dr. Matthew Bergtold
700 2nd Ave. N. # 203
Naples, FL 34102
Ph. 239-315-4694

Re: Our Privacy, Compliance with HIPAA Laws

The privacy of our patient information has always been important to us, and we have always been bound by professional standards of confidentiality. However, we are required by law to formally inform you of our privacy policy.

We collect nonpublic personal information about you that is provided by you or obtained by us with your authorization. This information may come from various sources, including information we receive from insurance companies that is necessary to provide professional services for you.

We do not disclose any nonpublic personal information about our patients or former patients to anyone, except as permitted or required by law, or when necessary to process transactions requested by a patient.

We restrict access to nonpublic personal information about you to members of our office who need to know that information in order to provide you with professional services. We retain record relating to the professional services that we provide you in accordance with professional and government guidelines.

We employ physical, electronic, and procedural security safeguards to protect your nonpublic personal information.

Your confidence and trust are important to us. If you have any questions or concerns regarding the privacy of your nonpublic personal information, please let us know.

Sincerely,

Matthew R. Bergtold, D.C.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

I, ______________________________, acknowledge that I have received a Notice of Privacy Practice in compliance with HIPAA Laws from the office of Advanced Chiropractic Health & Awareness Center, LLC on this date ______________.

____

Patient Signature