

Acct# \_\_\_\_\_ Provider# \_\_\_\_\_ FC \_\_\_\_\_ Fee \_\_\_\_\_ State \_\_\_\_\_ D/I \_\_\_\_\_

### CONFIDENTIAL PATIENT INFORMATION

(Please Print)

Patient's Name: \_\_\_\_\_  
First Middle Last

Home Address: \_\_\_\_\_ Apt#: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

What do you prefer to be called: \_\_\_\_\_ SS#: \_\_\_\_\_

Home#: \_\_\_\_\_ Work#: \_\_\_\_\_ Cell#: \_\_\_\_\_

Marital Status: M S W D Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Sex: M F  
Month Day Year

To receive monthly newsletter/special announcements, E-mail Address: \_\_\_\_\_

Employer's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Work Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employment Status: Full-Time Part-Time Self-Employed Retired Full-Time Student Part-Time Student

Spouse's Name: \_\_\_\_\_ Spouse's Employer: \_\_\_\_\_

Contact in case of an emergency: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone#: \_\_\_\_\_

Name of nearest relative not living with you: \_\_\_\_\_ Phone#: \_\_\_\_\_

Relative's Address: \_\_\_\_\_ Apt#: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Who referred you to our office? We'd like to thank them: \_\_\_\_\_

#### **Financial Information: (choose one)**

Today I will be paying with \_\_\_ Cash \_\_\_ Check \_\_\_ Credit Card

#### **If patient is under 18 years of age:**

I hereby authorize Dr. Chas B. Kubasko, Dr. Marc A. Burr, Dr. Kyle E. Waltz, Dr. Molly A. Leavitt, Brandy Allen, LMBT or whomever they may designate as their assistant to administer treatment, including X-rays and examinations, necessary to treat \_\_\_\_\_ at Crabtree Chiropractic Center.  
Minor's Name

#### **Signature of Parent or Legal Guardian**

I authorize Crabtree Chiropractic Center to release any information it deems appropriate concerning my physical condition to any insurance company, adjuster, or attorney in order to process my claim for reimbursement of charges incurred by me as a result of professional services rendered by Crabtree Chiropractic Center. I also authorize Crabtree Chiropractic Center to release any information it deems appropriate concerning my physical condition to my medical doctor.

I acknowledge that upon request I will be given the Notice of Privacy Practices of Crabtree Chiropractic Center PA, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created received or maintained by the Practice. I consent to Crabtree Chiropractic Center's use and disclosure of my Protected Health Information (any information, including my demographic information, created or received by the Practice, that relates to my past, present or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of healthcare services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me) for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice's general healthcare operations purposes.

I have received, reviewed, understand and agree to the Financial Policy of Crabtree Chiropractic Center PA, Raleigh NC

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

# Massage Therapy Information

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

Have you ever experienced a professional massage or bodywork session?  YES  NO How recently? \_\_\_\_\_

What are your massage or bodywork goals? \_\_\_\_\_

What kinds of pressure do you prefer?  light  medium  firm

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**If you answer “yes” to any of the following questions, please explain as clearly as possible.**

- |   |   |
|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you frequently suffer from stress?          | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you bruise easily?  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have diabetes?                          | <input type="checkbox"/> Yes <input type="checkbox"/> No Any broken bones in the past two year?   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you experience frequent headaches?          | <input type="checkbox"/> Yes <input type="checkbox"/> No Any injuries in the past two years?  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Are you pregnant?                              | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have tension or soreness in a specific area?<br>Please specify _____        |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you suffer from arthritis?                  | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have cardiac or circulatory problems?                                       |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Are you wearing dentures?                      | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you suffer from back pain?  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have high blood pressure?               | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have numbness or stabbing pains?  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Are you taking high blood pressure medication? | <input type="checkbox"/> Yes <input type="checkbox"/> No Are you sensitive to touch or pressure in any area?                                |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you suffer from epilepsy or seizures?       | <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had surgery? Explain below.  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you suffer from joint swelling?             | <input type="checkbox"/> Yes <input type="checkbox"/> No Other medical condition, or are you taking any<br>Medications I should know about? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have varicose veins?                    |   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have any contagious diseases?           | Comments _____  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have osteoporosis?                      | _____   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have any allergies?                     | _____   |

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat any physical or mental illness and that nothing said in the course of the sessions given should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session and I will be liable for payment of the scheduled appointment.

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Practitioner Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**Consent to Treatment of a Minor:** By my signature below, I hereby authorize \_\_\_\_\_ to administer massage, bodywork or somatic therapy techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_