Crabtree Chiropractic Center

Acct # _____ Provider # _____ CA _____

Patient's Legal Name: _____ **Nickname**: _____

Address: _____

City: _____ **State**: _____ **Zip**: _____

Primary Phone: _____ **Please Circle One** (Home Cell Work)

Email Address: _____ **Date of Birth**: _____/_____/_____

Sex: □ M □ F **Marital Status**: Single □ Married □ Widowed □ Divorced □

Spouse's Name: _____ **Spouse's Employer**: _____

Emergency Contact: _____ **Relationship**: _____ **Ph #:** _____

Which of our patient's referred you to our office? We'd like to thank them! _____

Have you ever been to a chiropractor before? □ No □ Yes If yes, Who & When: _____

Have you attended our Spinal Care Class? □ No □ Yes If yes, When:_____

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

Employer's Name: _____ **Occupation**: _____

Work Street Address: _____ **City**: _____ **State**: _____ **Zip**: _____

Family Physician (M.D.): _____ **Practice Name**: _____ **Ph. #:** _____

FEMALE'S ONLY: **Are you pregnant? □ No □ Yes Due Date**: _____/_____/_____

Is this visit the result of an injury? □ No □ Yes If yes, please check one below:

□ Auto Accident (_____/_____/_____) □ Work Injury (_____/_____/_____) □ Other Injury (_____/_____/_____)

Current Complaint(s): _____ **When did it begin**: (_____/_____/_____)

Please Explain: _____

_____

Race: □ American Indian or Alaska Native □ Asian
□ Native Hawaiian or Pacific Islander □ Black or African American
□ White/ Caucasian □ Patient Declined to Provide

Ethnicity: □ Not Hispanic or Latino □ Hispanic or Latino □ Patient Declined to Provide

Preferred Language: □ English □ Russian □ Japanese □ German □ Spanish □ French □ Decline to Specify

Smoking Status: □ Never □ Former Smoker (within the past 2 years)

Have you ever been diagnosed with high blood pressure/hypertension? □ No □ Yes

*__Note__: Any overpayment will remain on your account unless you advise us otherwise.

Crabtree Chiropractic Center

INFORMED CONSENT

***To the patient: Please read this entire document prior to signing it. It is very important that you understand the information contained in this document. If anything is unclear, please ask questions before you sign.

The nature of the chiropractic adjustment

The primary treatment used at Crabtree Chiropractic Center is spinal manipulative therapy. We will use that procedure to treat you. We may use hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As a part of the analysis, examination and treatment, you are consenting to the following core procedures: Spinal manipulative therapy, exercises, vital signs, range of motion testing, orthopedic testing, basic neurological testing, muscle strength testing, postural analysis testing, home instructions, hot/cold therapy, electrical stimulation, radiographic studies, mechanical traction, do's and don'ts for proper spinal hygiene and attendance at spinal care class.

The material risks inherent in chiropractic adjustment

As with any healthcare procedure, there are certain complications which may arise during treatment. These complications include but are not limited to: fractures, disc injuries, dislocations, stroke, muscle strain, cervical myelopathy, costovertebral strains and separations and burns. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform us before treatment begins.

The probability of those risks occurring

Any complications associated with chiropractic treatment are generally described as rare. Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and X-ray. The incidence of stroke is exceedingly rare and is estimated to occur between one in one million and one in five million cervical adjustments.

The availability and nature of other treatment option

Other treatment options for your condition may include:

Self – administered, over-the-counter analgesics and rest, massage, acupuncture, medical and prescription drugs such as anti-inflammatory, muscle relaxants and pain killers, hospitalization and/or surgery.

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU READ AND UNDERSTAND THE ABOVE.

***PLEASE CHECK THE APPROPRIATE OPTION BELOW*; then PRINT Name, SIGN & DATE.**

( ) I have read or… ( ) Someone has read to me... the above explanation of the chiropractic adjustment and any related treatment. I understand that any health concerns or questions will be discussed with the staff of Crabtree Chiropractic Center before treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Patient Print Name: X_____ Patient Signature: X _____

Date: X _____Crabtree Chiropractic Center Witness: _____

If patient is under 18 years of age: I hereby authorize any doctors at Crabtree Chiropractic Center or whoever they may designate as their assistant to administer treatment, including x-rays and examinations, necessary to treat _____ at Crabtree Chiropractic Center, PA ; Raleigh, NC._____

Minor's Name (print)

Signature of Parent or Legal Guardian

CRABTREE CHIROPRACTIC CENTER

Acct # _____

ACKNOWLEDGEMENT & RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for at least six years.

_____ _____

(Print) Patient Name Signature of Patient

_____ _____

Date Signature of Parent, Guardian or Patient's Legal Representative

AUTHORIZATION TO DISCLOSE PRIVATE HEALTH INFORMATION

List the name(s) below of any family members or person(s) you wish to have access to your private health information at our office.

First Name	Last Name	Relationship

This authorization will remain in effect until written notification instructing us otherwise