Crabtree Chiropractic Center P.A.

Office Use- Date: ________________ Acct # _________________ Provider # ____________ CA________

Patient Legal Name ***(FIRST, MIDDLE, LAST)*** ____ **Nickname:** ________________

Address: ____ **Apt#/Building#** ________________

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: ________________________________ **Phone** : ___________________ **Please Circle One** (Home Cell Work)

Emergency Contact: _____________________________ **Relationship**: ________________ **Ph #:** __________________

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 Only: **Are you pregnant?** □ **No** □ **Yes** **Due Date**: ________/________/__________

Which one of our patients referred you to our office? ***We would like to thank them!*** __________________________________

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

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 provide details (how it happened, what it feels like, etc.):

____

____

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) □ Current Every day Smoker

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

Crabtree Chiropractic Center P.A.

Acct # ___________________

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.

I understand 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:** ___________________________________

<u>If patient is under 18 years of age:</u> 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 P.A.

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****

Crabtree Chiropractic Center, PA

4517 Lead Mine Road, Raleigh NC, 27612
(919) 781-8830

Automobile Accident Questionnaire

Patient Name________________________________ **Today's Date**______________
(Please print)
Date of accident: __________________________________
Were you the Driver _______Passenger (Front/Back Seat) __________ Pedestrian _______?
Who else was in the vehicle? ____
Were you on the job at the time of the accident? ______ Yes ______ No
If yes, were you driving your vehicle or a company vehicle? _________________________________
Location of Accident: Street: ____________________ City: _______________ State: ____________
Were the police notified? _____ Yes _____ No was a ticket given? ____ Yes ___No
Who received the ticket? No one / other driver / don't know
Make of vehicle __________________Model of vehicle __________________Year of vehicle__________
Did the airbag(s) engage? _______ Yes _______ No
Amount of damage done to vehicle: No damage / Minimal, under $2,000 damage / Moderate, over $2,000 damage / Totaled, severe damage
If a total loss has occurred, what is the amount they determined the damage at? ______________________
What is the estimated value of your vehicle? _________________________
What is the make and model of the other vehicle involved? ____

History of Accident
_____ Stopped at red light or stop sign and rear ended.
_____ Head on collision - other vehicle traveling in opposite direction.
_____ Another vehicle ran a stop sign or red light.
_____ Did vehicle get hit into another vehicle or tree?
_____ Slowing down to make a stop or turn - rear ended.
_____ Lost control of vehicle____ Spun around _____ Rolled over.
_____ Side swiped.
_____ "T-Boned"?
_____ Other ____

Were you wearing seat belt / shoulder strap? ______ Yes ______ No
Did the seatbelt and shoulder strap engage? ______ Yes ______ No

Did you strike any objects inside the car? ______ Yes _______ No
_____ Steering column
_____ Dash Board
_____ Windshield
_____ Headrest
_____ Door Frame
_____ Jarred or thrown about
_____ Rear view mirror
_____ Seat Broke
_____ Cannot remember detail (dazed)
_____ Other______________________________
____

Which way was your head turned at the time of impact? ____ right ____ left ____ straight
Were you leaning forward at the time of impact? _____ Yes ______ No
Was your body turned at the time of impact? ____ right ___ left ____ straight
Did you know you were going to be hit? ____ Yes ____ No If so, did you brace yourself? ____ Yes ___ No
What portion of your body did you strike? _____ Head, where in the vehicle? Steering column, side window, front window, rear window (truck) or headrest _____ Chest _____ Face _____ Knees _____ Arms
______Other____

Patient Signature____ **Date** ______________________

Patient Name________________________________ **Today's Date**______________
(Please print)

Were you rendered unconscious, cut, or bleeding? _____ Yes _____ No
If cut, please explain where: ____

Did you experience immediate pain, please indicate:
_____ Headache ____ right ____ left
_____ Neck pain ____ right ____ left
_____ Mid back pain ____ right ____ left
_____ Low back pain ____ right ____ left
_____ Leg pain ____ right ____ left
_____ Arm pain ____ right ____ left
_____ Other ____

After the accident, did you:
_____ Go Home _____ Go about your business _____ Go to the hospital

HOSPITALIZATION

If taken to the hospital, how? ____ Ambulance _____ Drove myself
____ Driven by a friend/relative ____Went home and later taken or drove to the hospital.

Name of Hospital: ____
___ Western Wake ___ Raleigh Community ____Wake Medical ___ Rex ____Other

Were you seen in the emergency room? _____ Yes _____ No
Were you admitted to the hospital? _____ Yes _____ No
If admitted, how long did you stay? ____
Name of admitting or hospital physician: ____

In the emergency room or hospital, what was done?
______ Examination _______ Stitches
______ X-rays _______ Physical Therapy
______ Cervical Collar _______ Complete Bed rest
______ Prescription given _______ Hot or cold therapy
______ Referral to another doctor _______ Other: ____

After your release what did you do?
_____ Return home to bed _____ Return to work
_____ Other ____

When did you first consult a physician?
____ Same day ____ Following day ____ Within a few days ____ Other: ________________________________

If you consulted this office first, skip to PAST HISTORY.

Who did you consult? Dr. ____
_______ Family physician _______ Chiropractor
_______ Orthopedist _______ Osteopath
_______ Neurologist _______ Other: ____

Patient Signature____ **Date** _______________________

Patient Name____ **Today's Date**____________

(Please print)

What did the doctor do?

______ Chiropractic manipulation
______ Injections
______ Traction
______ Physical Therapy

_______ Examination
_______ X-rays
_______ Prescriptions
_______ Other: ____________________________________

If physical therapy was rendered, how long: ____

Where did you receive these treatments?

______ Hospital ______ At Primary Care Physician office

How long were you under the care of this physician? ____

Are you still under his/her care? _______ Yes ______ No

Frequency or number of visits now: ____

Did the doctor refer you to or have you been to any other physicians? ____ Yes ____ No

Explain: ____

Other pertinent information: ____

____

PAST HISTORY

Have you ever been in a previous auto accident? _______ Yes ______ No

If yes, please give dates and details: ____

____

____

Do you have lasting symptoms or are you still being treated for that accident? If yes, please explain:

____

____

Have you ever been treated for neck or back problems by any other physicians prior to this current accident? _______ Yes _______ No If yes, please explain: ____

____

Have you enjoyed good health prior to this accident? _____ Yes _____ No

If no, explain: ____

DISABILITY

Have you lost any time from work since the accident? _______ Yes _______ No

How many days? ____________________ Still off work? ________ Yes _________ No

Job Description: ____

Any additional comments or details you feel would be helpful regarding this accident?

____

Patient Signature____ **Date** ______________________