



**Crabtree Chiropractic Center**

Date: \_\_\_\_\_ Acct # \_\_\_\_\_ Provider # \_\_\_\_\_ CA \_\_\_\_\_

Patient LEGAL Name (FIRST, MIDDLE, LAST): \_\_\_\_\_

What you prefer us to call you (First Name - 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 \_\_\_\_\_

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  Occasional/Social Smoker

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.



**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 viewing or attendance of our spinal care class or videos.

**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:** \_\_\_\_\_

**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**



**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\****