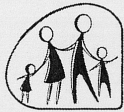
Date: ________________ Acct # __________________ Provider # ____________ CA ________



# Crabtree Chiropractic Center

**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

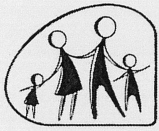
**Ethnicity**: □ Not Hispanic or Latino □ Hispanic or Latino □ Patient Declined to Provide

**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.



**Crabtree**
**Chiropractic**
**Center**

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 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.**

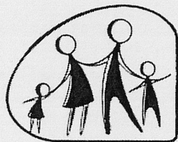
I understand the above explanation of the chiropractic adjustment and any related treatment. I understand that any health concerns or questions will be discussed with the staff of Crabtree Chiropractic Center before treatment. By signing below, I state that I have weighed the risks involved in undergoing 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**



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****

# 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** ______________________

# Crabtree Chiropractic Center, PA

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

## Accident Occupational Evaluation Form

**Patient Name**_________________________________ **Date** ____________
(Please Print)

To help us determine the daily demands placed on you and how it may be affecting your progress at our office please put a check in front of ALL that apply:

( ) prolonged standing
( ) prolonged sitting
( ) kneeling, squatting, or crawling
( ) repetitive load handling
( ) pushing or pulling objects
( ) twisting the torso to one side while lifting
( ) unbalanced lifting of heavy weights (such as a full 5-gallon paint can) with one hand
( ) repetitive or sustained stooping or bending over
( ) reaching and lifting overhead
( ) stair climbing
( ) ladder climbing
( ) working at unprotected heights
( ) walking on slick, slippery, cluttered or uneven surfaces
( ) operating foot controls always with the same foot
( ) operating awkward hand controls or keyboards that keep the wrist in an unnatural position
( ) operating moving machinery
( ) driving automotive equipment
( ) exposure to dust, fumes, gases, solvents or chemicals
( ) lifting loads at the beginning of the work shift
( ) lifting loads at the end of the work shift
( ) have you been on the job for less than 6 months
( ) are you shorter or thinner than your co-workers?
( ) maintaining a twisted position of the neck or back for prolonged period (such as looking to the side while typing)
( ) handling loads which require awkward body postures such as having to bend and reach out to an object that cannot be held close to the body in an erect posture

______ **Total Number of checks** = SCORE

**Patient Signature:** ________________________________________

(Developed by Greater Houston area chapter of the American Red Cross sponsored by the American Chiropractic Association)

**Review of Systems**: Please indicate any personal history prior to your injury.

Crabtree Chiropractic Center P.A. Raleigh, NC 27612

**CONSTITUTIONAL SYMPTOMS**

| | | |
|---|---|---|
| Good general health lately | Yes | No |
| Recent weight change | Yes | No |
| Fever | Yes | No |
| Fatigue | Yes | No |
| Headaches | Yes | No |

**EYES**

| | | |
|---|---|---|
| Eye disease or injury | Yes | No |
| Wear glasses/contact lenses | Yes | No |
| Blurred or double vision | Yes | No |

**EARS/NOSE/MOUTH/THROAT**

| | | |
|---|---|---|
| Hearing loss or ringing | Yes | No |
| Earaches or drainage | Yes | No |
| Chronic sinus problems or rhinitis | Yes | No |
| Nose bleeds | Yes | No |
| Mouth sores | Yes | No |
| Bleeding gums | Yes | No |
| Bad breath or bad taste | Yes | No |
| Sore throat of voice change | Yes | No |
| Swollen glands in neck | Yes | No |

**CARDIOVASCULAR**

| | | |
|---|---|---|
| Heart trouble | Yes | No |
| Chest pain or angina pectoris | Yes | No |
| Palpitation | Yes | No |
| Shortness of breath with walking or lying flat | Yes | No |
| Swelling of fee, ankles, or hands | Yes | No |

**RESPIRATORY**

| | | |
|---|---|---|
| Chronic or frequent coughs | Yes | No |
| Spitting up blood | Yes | No |
| Shortness of breath | Yes | No |
| Wheezing | Yes | No |

**GASTROINTESTINAL**

| | | |
|---|---|---|
| Loss of appetite | Yes | No |
| Change in bowel movements | Yes | No |
| Nausea or vomiting | Yes | No |
| Frequent diarrhea | Yes | No |
| Painful bowel movements or constipation | Yes | No |
| Rectal bleeding or blood in stool | Yes | No |
| Abdominal pain | Yes | No |

**GENITOURINARY**

| | | |
|---|---|---|
| Frequent urination | Yes | No |
| Burning or painful urination | Yes | No |
| Blood in urine | Yes | No |
| Change in force of strain when urinating | Yes | No |
| Incontinence or dribbling | Yes | No |
| Kidney stones | Yes | No |
| Sexual difficulty | Yes | No |
| Male-testicle pain | Yes | No |
| Female-pain with periods | Yes | No |
| Female-vaginal discharge | Yes | No |

Female-# of pregnancies: __________

Female-# miscarriages: __________

Female-date of last pap smear: __________

**MUSCULOSKELETAL**

| | | |
|---|---|---|
| Joint pain | Yes | No |
| Joint stiffness or swelling | Yes | No |
| Weakness of muscles or joints | Yes | No |
| Muscle pain or cramps | Yes | No |
| Back pain | Yes | No |
| Cold extremities | Yes | No |
| Difficulty in walking | Yes | No |

**INTEGUMENTARY** (skin, breast)

| | | |
|---|---|---|
| Rash or itching | Yes | No |
| Change in skin color | Yes | No |
| Change in hair or nails | Yes | No |
| Varicose veins | Yes | No |
| Breast pain | Yes | No |
| Breast lump | Yes | No |
| Breast discharge | Yes | No |

**NEUROLOGICAL**

| | | |
|---|---|---|
| Frequent or recurring headaches | Yes | No |
| Light headed or dizzy | Yes | No |
| Convulsions or seizures | Yes | No |
| Numbness or tingling sensations | Yes | No |
| Tremors | Yes | No |
| Paralysis | Yes | No |
| Head injury | Yes | No |

**PSYCHIATRIC**

| | | |
|---|---|---|
| Memory loss or confusion | Yes | No |
| Nervousness | Yes | No |
| Depression | Yes | No |
| Insomnia | Yes | No |

**ENDOCRINE**

| | | |
|---|---|---|
| Glandular/hormone problem | Yes | No |
| Excessive thirst or urination | Yes | No |
| Heat or cold intolerance | Yes | No |
| Skin becoming dryer | Yes | No |
| Change in hat or glove size | Yes | No |

**HEMATOLOGIC/LYMPHATHIC**

| | | |
|---|---|---|
| Slow to heal after cuts | Yes | No |
| Bleeding or bruising tendency | Yes | No |
| Anemia | Yes | No |
| Phlebitis | Yes | No |
| Past transfusion | Yes | No |
| Enlarged glands | Yes | No |

**ALLERGIC/IMMUNOLOGIC**

History of skin reaction or other adverse reaction to:

| | | |
|---|---|---|
| Penicillin or other antibiotic | Yes | No |
| Morphine, Demerol, or other narcotics | Yes | No |
| Novocain or other anesthetics | Yes | No |
| Aspirin or other pain remedies | Yes | No |
| Tetanus antitoxin or other serums | Yes | No |
| Iodine, methiolate or other antiseptics | Yes | No |

Other drugs/medication:

______________________________
______________________________
______________________________
______________________________
______________________________
______________________________

Known food allergies:

______________________________
______________________________
______________________________
______________________________
______________________________
______________________________

Environmental allergies:

______________________________
______________________________
______________________________
______________________________
______________________________
______________________________

**AUTHORIZATION AND RELEASE**

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the health care staff to perform the necessary services I may need.

**Patient Name:** ______________________ **Signature of Patient**: ____________________________ **Date:** ______________