

Kapeikis Chiropractic & Massage, P.S.

"Active Care for Active Lifestyles"

630 N. Chelan Ave. Ste. B-2, Wenatchee, WA 98801, phone: 509-665-8363, fax: 509-662-7274

Thank you for choosing Kapeikis Chiropractic & Massage, P.S.

You have opened the intake packet indicating you will be visiting our office for

MASSAGE CARE ONLY

If your symptoms are related to a
CAR ACCIDENT, WORK INJURY, or THIRD PARTY LIABLE INJURY
or you are planning on
CONCURRENT CHIROPRACTIC CARE with Dr. Kapeikis,
please go back and find the appropriate "intake packet".

Our pre-exam question forms are designed to help us provide you with the best care possible. Please print the following pages, fill out what is relevant to your current symptoms and bring the completed forms with you to your 1st appointment.

If you were referred for massage by another physician,
please bring your referral with you to your 1st visit.

Thank you for taking the time to help us
provide appropriate and efficient care for you.

Sincerely,

Paul Kapeikis, D.C.

Kapeikis Chiropractic & Massage, P.S.

"Active Care for Active Lifestyles"

630 N. Chelan Ave. Ste. B-2, Wenatchee, WA 98801, phone: 509-665-8363, fax: 509-662-7274

ABOUT YOU

Name: _____ Birth Date: ____/____/____
Social Security Number _____ - _____ - _____ Married Partner Single Female Male
Home Address: _____ City: _____
State: _____ Zip: _____ Telephone Number: _____ Cell: _____
Email: _____
Parent or Spouse: _____
Emergency Contact _____ Phone # _____
Were you referred to our office? NO YES by: _____

ACCOUNT INFORMATION

I authorize the release of my records to my insurance company and to **relevant** health care providers for the purposes of collecting insurance payments and continuity of care.

I authorize assignment of my insurance benefits directly to Kapeikis Chiropractic & Massage, PS. I agree that my account is due within 90 days of the date of service, and that I am ultimately responsible for full payment regardless of insurance coverage. I agree that I will be responsible for all expenses incurred in collecting a past due account.

Patient Signature: _____ Date: _____

Parent Signature (for patients under age 18): _____

CONSENT TO PARTICIPATE

Therapeutic procedures conducted in this office are considered safe and effective methods of care. As with any procedure intended to help, complications may arise. These complications include increased pain, swelling, bruising, muscle strain and discomfort, burns, lightheadedness, fainting or a temporary worsening of symptoms. More serious complications are extremely rare. Additional information concerning side-effects and complications is always available upon request.

Your participation is voluntary.

I have read and understand the above statements regarding treatment side effects. I also guarantee that this form was completed correctly to the best of my knowledge. I understand it is my responsibility to inform this office of any changes in the above information

Patient Signature: _____ Date: _____

Parent Signature (for patients under age 18): _____

Kapeikis Chiropractic & Massage, P.S.

"Active Care for Active Lifestyles"

630 N. Chelan Ave. Ste. B-2, Wenatchee, WA 98801, phone: 509-665-8363, fax: 509-662-7274

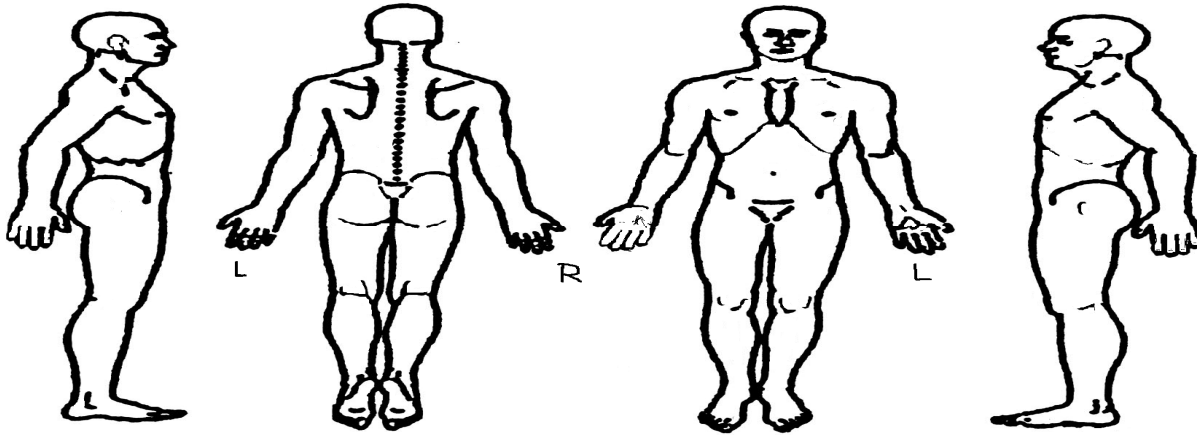
NAME: _____

DATE: _____

PRE-MASSAGE QUESTIONNAIRE

1. Please indicate on the drawings where you notice your symptoms.

Please feel free to add your own SYMPTOM description including radiation or referral.



2. Problem(s) began/noticed/aggravated on: _____ (*Date Required for Insurance*)

3. How did this problem start/mechanism of injury: _____

_____ (*Required for Insurance*)

4. Please list any past significant surgeries or physical injuries. (Approx. Dates) _____

5. Are you taking any blood thinning medication or supplements? Yes No

6. Do you have any areas of numbness, hypersensitivity or neuropathy? Yes No

7. Any history of reactions to massage lotions? Yes No

8. Is there any chance you could be pregnant now? Yes No

9. Within the recent past, have you experienced: fever, nausea, fainting, dizziness, shortness of breath, unexplained extreme fatigue, rapid or skipping heart beat, severe constipation or diarrhea, blood in urine or stool, or unexplained weight loss or gain. Yes (please circle) No

10. Do you have any medical conditions your therapist should know about prior to your massage? _____

Signature _____