



Crimson Chiropractic Center

You deserve to feel good

"The doctor of the future will give no medicine but will interest his patients in the care of the human frame, in diet, and in cause and prevention of disease." --Thomas Edison

Patient Information

Thank you for choosing this practice for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, please do not hesitate to ask for assistance. We will be happy to help.

(Please Print)

Name _____ Date _____ S.S.# _____ - _____ - _____

First Middle Last
Address _____ City _____ St. _____ Zip _____

Sex: Male Female Age _____ Birth Date _____ e-mail _____

Home Phone # _____ Work Phone # _____ Cell Phone # _____

Employer _____ Spouses Name _____

Emergency Contact Name _____ Ph# _____

Who referred you to us? Name: _____

Doctor Friend/Family Yellow Pages Internet Ins Co. Other

Check Your Symptoms Below

- | | | |
|---|---|-------------------------------------|
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Low back or tailbone Pain | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Arm pain | <input type="checkbox"/> Leg Pain | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Pain Between Shoulders | <input type="checkbox"/> Numbness/Tingling | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Clicking Jaw | <input type="checkbox"/> Painful/Discolored Urination | <input type="checkbox"/> Sinuses |

Other (Describe) _____

Which of the Above Symptoms Bothers You the Most? _____

Is this Problem a **DIRECT** Result of an Automobile Accident or on the Job Injury? Yes No

Insurance Information

Insurance Co. Name _____ Secondary Ins _____

Name on Insurance Card ("Insured") _____ "Insured" Birth Date _____

Method of Payment Today: Cash Check Credit Card

Would you like a copy of "Notices of Privacy Practices" that describes how your health information may be used and disclosed and how you can get access to this information? Yes No If yes; Please tell receptionist.

X _____ Date: _____
Signature of Patient (or Parent if Minor)

PAIN LOCATION

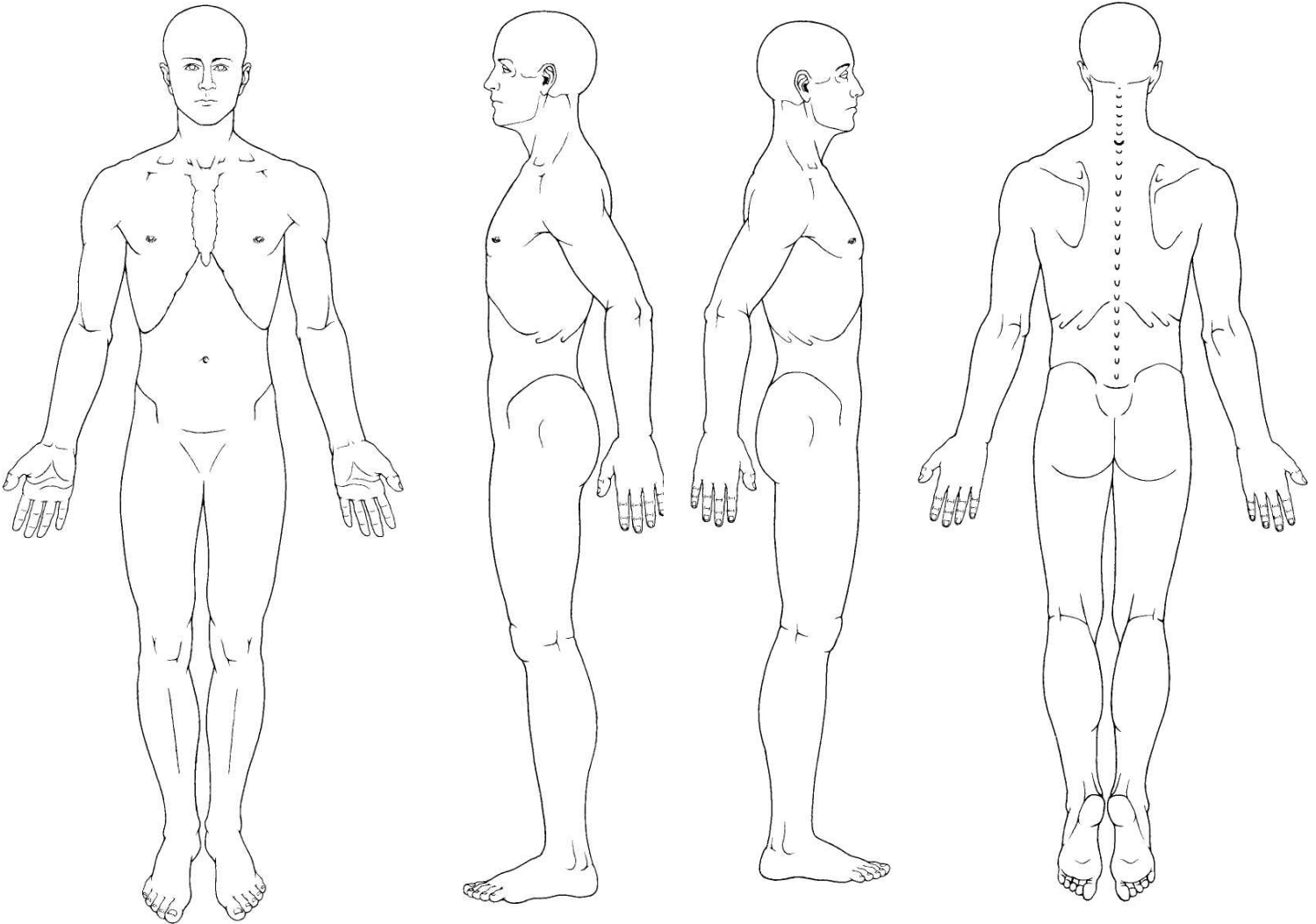
Step 1 Please put an “X” on the line describing the intensity of your pain at its worse.

No Pain | _____ | _____ | _____ | _____ | Unbearable Pain

Step 2 Mark the areas on the body diagram below where you feel pain or unusual symptoms.

Please use the following symbols to describe your condition.

- PPP** Where you experience Pain
- NNN** Where you experience Numbness
- TTT** Where you experience Tingling
- BBB** Where you experience Burning
- CCC** Where you experience Cramping



PATIENT SIGNATURE _____ DATE _____

GENERAL PAIN QUESTIONNAIRE

Name _____

Date _____

Please Read:

This survey asks for your views about how your pain now affects how you function in everyday activities. This information will help you and your doctor know how you feel and how well you are able to do your daily tasks at this time.

Please answer every question by making an "X" along the line to show how much your pain problem has affected you (from having no problems at all to having the most severe problems you can imagine).

BE SURE TO ANSWER ALL QUESTIONS

1. **Family/At-Home Responsibilities** such as: yard work, chores around the house or driving the kids to school.

Completely able to function] _____] _____] _____] _____] _____] Totally unable to function

2. **Recreation** Including hobbies, Sports, or other leisure activities

Completely able to function] _____] _____] _____] _____] _____] Totally unable to function

3. **Social Activities** including parties, Theatre, concerts, dining-out, and attending other social activities

Completely able to function] _____] _____] _____] _____] _____] Totally unable to function

4. **Employment** including volunteer work and Homemaking tasks

Completely able to function] _____] _____] _____] _____] _____] Totally unable to function

5. **Self Care** such as taking a shower, driving, or getting dressed

Completely able to function] _____] _____] _____] _____] _____] Totally unable to function

6. **Life-support** Activities such as eating and sleeping

Completely able to function] _____] _____] _____] _____] _____] Totally unable to function

PAST MEDICAL HISTORY

Approximate Date(s) of Any Previous Episodes: _____

Have You Ever Had Any Spinal Injuries? **Y N** _____

Have You Ever Had Cancer? -----**Y N** When? _____

Do You Have Diabetes?-----**Y N** _____

Have You Ever Had A Stroke? -----**Y N** _____

What Is/Was Your Occupation? _____

Approximate Date of Last Physical Exam: _____

Chiropractic History:

Have you Ever Been to a Chiropractor Before? **Y N** If Yes Dr.'s Name _____

Date of Last Chiropractic Visit _____ Reason for Care _____

Date of Last Chiropractic X-rays _____ How Long were you Under Care? _____

Other Treatments For This Condition:

Name of Treating Physician _____ Approximate Dates _____

Type of Treatment or Drugs Prescribed _____

Name of Treating Physician _____ Approximate Dates _____

Type of Treatment or Drugs Prescribed _____

Past Surgeries or Hospitalizations:

Type _____ Approximate Date _____

Type _____ Approximate Date _____

Type _____ Approximate Date _____

Hospitalizations (Other than noted surgeries) _____

Previous Accidents and Falls:

What _____ Approximate Date _____

What _____ Approximate Date _____

All HEALTH CONDITIONS that you are Currently Taking Medication For:

Wellness Commitment:

At Crimson Chiropractic we are dedicated toward achieving the goal of total lasting health for our members. To better help you achieve this, we need to understand your commitment toward being healthy. We do not ask for a *financial commitment*, but we do ask for your *cooperative commitment*. Based on a scale of 10% to 100%, please **circle** your personal level of commitment toward obtaining and maintaining health and wellness.

10%-----20%-----30%-----40%-----50%-----60%-----70%-----80%-----90%-----100%

PATIENT SIGNATURE _____ DATE _____

REVIEW OF SYSTEMS

PLEASE CIRCLE ANY THAT APPLY TO YOU:

GENERAL INFORMATION:

ANY RECENT WEIGHT GAIN/LOSS-----Y N
WEAKNESS----- Y N
UNUSUAL FATIGUE----- Y N
FEVER----- Y N
FAINTING SPELLS----- Y N
NAUSEA----- Y N
VOMITING-----Y N
BALANCE PROBLEMS----- Y N
JOINT SWELLING----- Y N
DEPRESSION----- Y N
LIVER PROBLEMS----- Y N
METAL IMPLANTS----- Y N

HEAD:

HEADACHES----- Y N
LOSS OF CONSCIOUSNESS-- Y N
DIZZINESS----- Y N
MEMORY PROBLEMS----- Y N
SEIZURES/CONVULSIONS--- Y N

EYES:

DOUBLE VISION----- Y N
BLURRED VISION----- Y N
LOSS OF VISION----- Y N
EYES SENSITIVE TO LIGHT-- Y N

EARS:

LOSS OF HEARING----- Y N
RINGING IN EARS (TINNITIS)Y N
EAR INFECTIONS----- Y N
VERTIGO (DIZZINESS)----- Y N
DISCHARGE FROM EARS---- Y N

NOSE:

SINUS PROBLEMS----- Y N
EPITAXIS (NOSEBLEEDS)---- Y N
LOSS OF SMELL----- Y N

MOUTH/THROAT:

TOOTH PAIN----- Y N
LESIONS / SORES IN MOUTH, LIPS OR GUMS---- Y N
FREQUENT SORE THROATS----- Y N
DIFFICULTY SWALLOWING----- Y N

GI (GASTROINTESTINAL):

LOSS OF APPETITE----- Y N
INDIGESTION----- Y N
CONSTIPATION----- Y N
DIARRHEA----- Y N
BLOODY STOOL----- Y N
ABDOMINAL PAIN----- Y N
LOSS OF BOWEL CONTROL-- Y N

RESPIRATORY (LUNG PROBLEMS):

DIFFICULTY BREATHING----- Y N
CHRONIC COUGH----- Y N
ASTHMA----- Y N
BRONCHITIS----- Y N
EMPHYSEMA----- Y N
EVER HAVE TUBERCULOSIS----- Y N

CARDIOVASCULAR (HEART PROBLEMS):

HEART ATTACK----- Y N
CHEST PAIN----- Y N
SHORTNESS OF BREATH---- Y N
PALPITATIONS----- Y N
NIGHT SWEATS----- Y N

ENDOCRINE:

COLD OR HEAT INTOLERANCE----- Y N
EXCESSIVE SWEATING----- Y N
EXCESSIVE THRIST----- Y N
THYROID PROBLEMS----- Y N
KIDNEY PROBLEMS----- Y N
DIABETES----- Y N
(IF YES INSULIN DEPENDENT)--Y N

SOCIAL HISTORY:

USE TOBACCO --Y N
(IF YES INDICATE HOW MUCH AND HOW LONG) _____

USE ALCOHOL----- Y N
(IF YES INDICATE HOW OFTEN AND HOW MUCH) _____

USE RECREATIONAL DRUGS--- Y N
(IF YES INDICATE WHAT AND HOW OFTEN) _____

ANY SEXUAL TRANSMITTED DISEASE (STD'S)--- Y N _____

MALES:

PROSTATE PROBLEMS----- Y N
HERNIAS----- Y N
PENILE DISCHARGE----- Y N
BLOOD IN URINE----- Y N
PAINFUL URINATION----- Y N
FREQUENT URINATION----- Y N
TESTICULAR PAIN----- Y N
LOSS OF BLADDER CONTROL----- Y N

FEMALES:

HISTORY OF PELVIC INFLAMMATORY DISEASE----- Y N
URINARY TRACT INFECTIONS----- Y N
BREAST CANCER &/ OR BENIGN TUMORS----- Y N
BLOOD IN URINE----- Y N
PAINFUL URINATION----- Y N
LOSS OF BLADDER CONTROL----- Y N
CURRENTLY PREGNANT----- Y N

FAMILY HISTORY:

Does anyone of your close relatives (Sisters, Brothers, Parents, Grandparents, Children, Uncles, Aunts) have/had any of the following diseases:

ALLERGIES, CANCER, DIABETES, VENOUS THROMBOSIS OR
ATHEROSCLEROSIS, HEART RELATED CHEST PAIN OR HEART ATTACK,
STROKE , PSYCHIATRIC DISEASE, OTHER CHRONIC DISEASES

PATIENT SIGNATURE: _____ DATE: _____

Authorization for Release of Protected Health Information

Highlighted areas must be filled out

Name of Patient: _____	
Address: _____	
Date of Birth: _____	SSN: _____ - _____ - _____

I understand that I do not need to sign this authorization to assure treatment. I also understand that I may inspect or copy the information to be disclosed.

Purpose of this Request: For use by Dr. David Richardson or his associates for chiropractic evaluation and treatment.

Information to be used or disclosed (Medical records/reports etc) _____

Information that MAY NOT be used or disclosed: _____
--

Name of the facility (Clinic, Hospital etc) or person I am authorizing to disclose my protected health information: _____

Expiration Date: _____ If left blank, this authorization will expire one year after the date of this authorization.

Right to revoke: I understand I have the right to revoke this authorization in writing. I understand that the revocation is only effective after it is received and logged.

Subsequent Disclosure: Disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Patient Signature or Personal Representative

Today's Date

As authorized representative, I have the authority to act for the individual because I am: _____

Patient Authorizations

1. **Assignment of Benefits**

I hereby instruct and direct my insurance company to pay by check made out to and mailed to Dr. David Richardson. This is a direct assignment of my rights and benefits under this policy.

2. **Financial Agreement**

I agree to be financially responsible for all charges incurred at this clinic including my insurance deductible, copayment, and any other services rejected by my insurance company. I agree to pay all cost of collection including interest at 18% per annum, court cost and attorney fees.

3. I have read or have had read to me the above authorization. I have also had an opportunity to ask questions about its content, and by signing below, **Agree To All Terms**. This authorization shall remain in effect unless changed by written request.

Printed Name

Date of Birth

Signature

Today's Date