Please fill out our Health Record as completely and accurate as possible.
You may submit via our online link or download, print and bring them with you to your first visit.

It is our pleasure to be of service to you.

Patient Information

First Name ______________________ **Last Name** ______________________

Street Address ______________________

City ______________ **State/Province** ______________ **Zip Code** ______________

Phone ______________________ **Cell Phone** ______________________

Birthday ______________ **Age** ______________ **Gender** ◯ Male ◯ Female ◯ Other

Employer ______________________

Work Phone ______________________ **Type of Work** ______________________

Email ______________________ **Social Security #** ______________________

Emergency Contact

First Name ______________________ **Last Name** ______________________

Phone Number ______________________

Check Your Symptoms below

Please check all that apply:

- ☐ Neck
- ☐ Chest Pain
- ☐ Numbness/Tingling
- ☐ Leg Pain
- ☐ Pain Between Shoulders
- ☐ Arm Pain
- ☐ Headache
- ☐ Painful or Discolored Urine
- ☐ Hip Pain
- ☐ Low Back Pain
- ☐ Shoulder
- ☐ Dizziness

Other (describe)

____

Which of the Above Symptoms Bother you the Most

____

Have you had any other treatment for this condition?

____

Have you ever been to a Chiropractor before?

☐ No ☐ Yes

Approximate date of last visit

____

Have you ever had any Spinal Injuries?

☐ Yes ☐ No

Have you ever had Cancer?

☐ Yes ☐ No

Do you have Diabetes

☐ Yes ☐ No

Have you ever had a Stroke

☐ Yes ☐ No

All health Conditions that I currently take medication for:

____

Who referred you to this office?

____

FOR WOMEN ONLY:

Are you pregnant?

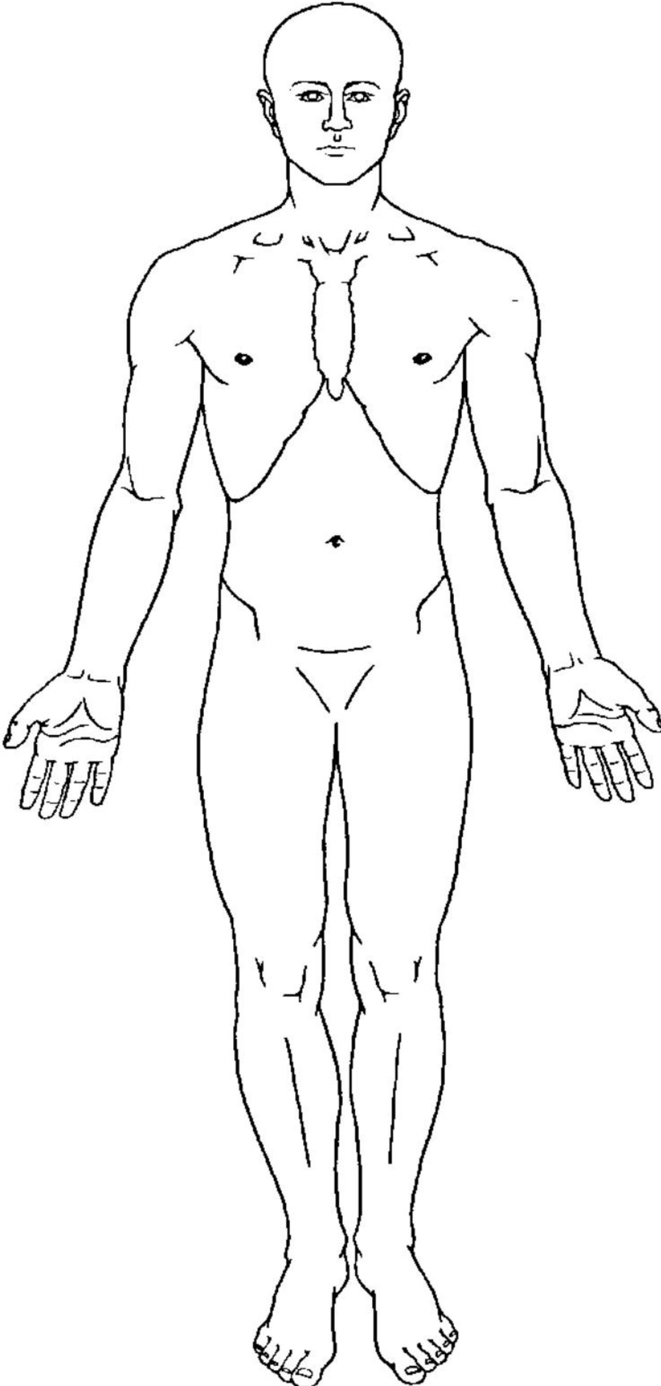
☐ Yes ☐ No

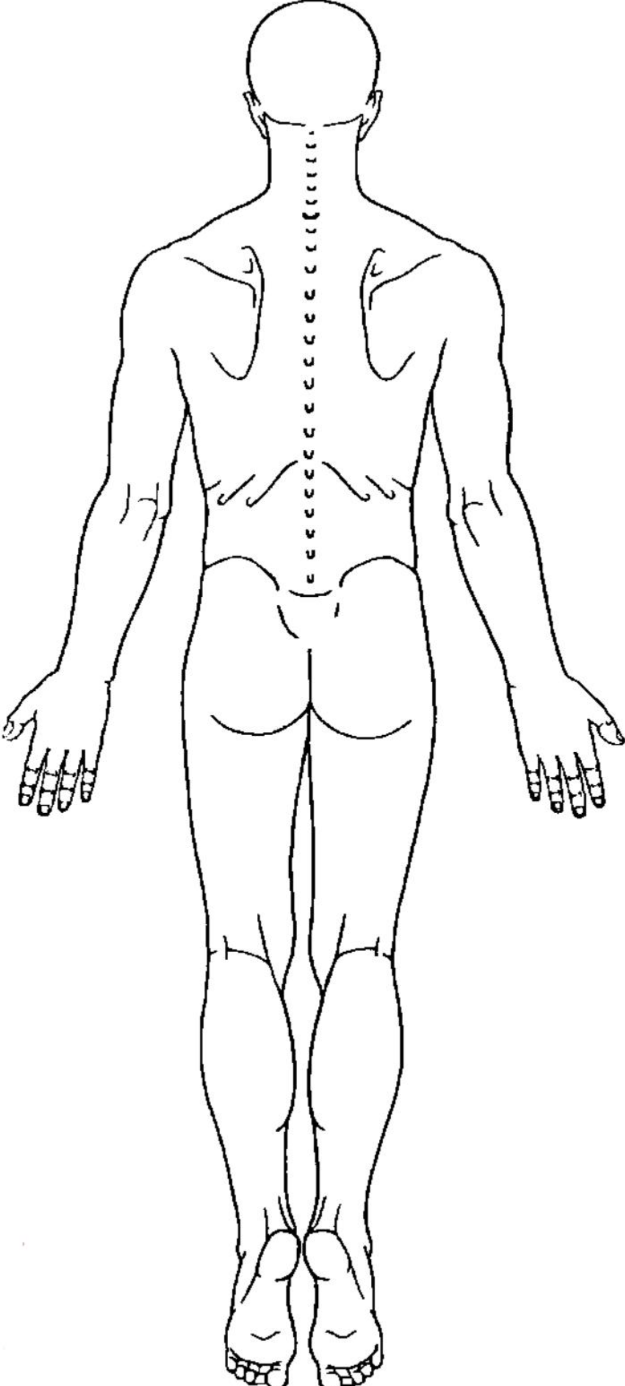
Do you have breast implants?

☐ Yes ☐ No

Place an X on the image below, where you feel pain, numbness or tingling:

Mark your Pain Point





Goals for my Care

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of their pain, and others for correction of whatever is malfunctioning in their bodies. Your Doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

Relief Care: Symptomatic relief of pain or discomfort

☐ Yes

Corrective Care: Correcting and relieving the cause of the problem as well as the symptoms

☐ Yes

Comprehensive Care: Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care.

☐ Yes

My Health Insurance

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself . I understand that the Doctor's Office will provide any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account upon receipt.

Insurance Company

____

Policy # ______________________________

Group # ______________________________

ABOUT THE INSURED PERSON
(Persons name on Insurance card)

First Name ______________________________

Last Name ______________________________

Date of Birth ______________________________

Relation ______________________________

Missed Appointments

We strive to provide you with the utmost professionalism and excellence of service. Our commitment to your well-being and health is something we take seriously.

We care about you and realize it would be a disservice to you if we did not emphasize the importance of your own commitment to the care you need and to the actions we recommend to you.

- Your faithfulness to the recommended number of adjustments is key to ensuring optimum results.
- With the exception of emergencies, it is vital that you keep all your appointments. Reminder cards are provided to help you save the date. If you need to re-schedule an appointment, please call our office and arrange for a make-up appointment with our chiropractic assistants. We would prefer the make up appointment to be within the same week.

Thank you for your understanding. We greatly appreciate you as our patient and strongly desire excellent results and success for you!

I understand and agree to all the information written above.

Patient's Signature ______________________ **Date** ____________

Today's payment will be made by:

☐ Cash ☐ Check
☐ Credit Card

Assignment of Benefits:

I hereby instruct and direct my insurance company to pay any benefits from services rendered directly to Crimson Chiropractic. This is a direct assignment of my rights and benefits under this policy.

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.

I have read or have had read to me the above authorizations. 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.

Patient Signature

____

Date

____