Dr. James E. Hollingsworth
• Chiropractic Physician
• Diplomate American Academy of Pain Management
• Clinical Member American Psychotherapy and Medical Hypnosis Association

HELPING YOU EXCEL

New Patient Form

Please fill out completely

Name_____ Social Security #_____ Date_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ E-Mail Address_____

Birth date _____ Age_____ Marital Status M S W D How many Children?____ Nearest Relative_____

Referred to our office by_____ Address_____

Your Occupation_____ Employer Name_____

Employer's Address_____ Off. Phone_____

Spouse's Name_____ Soc. Sec. #_____ Spouse's Birth date _____

Employer_____ Employer's Address _____

Previous Chiropractic Care? Yes / No Chiropractor's Name_____

Purpose of this appointment (major complaint)_____

_____

What do you believe caused your problem?_____

What activities aggravate this condition?_____

Did this condition arise from an auto accident or employment?_____ **If Yes, Please Tell Receptionist.**

Is this condition getting progressively worse? Yes / No Pain: Constant____ Intermittent_____

Is this condition interfering with your: Work__ Sleep__ Daily Routine__ Other__ Days lost from work____

Other physicians seen for this condition_____

Date of onset of your symptoms:_____ Ladies: Are you pregnant? _____

Check any of the following: (√) Current problem [√] Occurred in the past

- ○ ☐ Allergies
- ○ ☐ Dizziness
- ○ ☐ Fatigue
- ○ ☐ Headache
- ○ ☐ Loss of sleep
- ○ ☐ Ulcers
- ○ ☐ Nervousness
- ○ ☐ Depression
- ○ ☐ Arthritis
- ○ ☐ Bursitis
- ○ ☐ Swollen joints
- ○ ☐ High Stress
- ○ ☐ Neck pain
- ○ ☐ Sciatica
- ○ ☐ Difficult digestion
- ○ ☐ Nausea
- ○ ☐ Asthma
- ○ ☐ Ear noises
- ○ ☐ Eye pain
- ○ ☐ High blood pressure
- ○ ☐ Bruise Easily
- ○ ☐ Sinus infection
- ○ ☐ Pain over heart
- ○ ☐ Poor Circulation
- ○ ☐ Chest pain
- ○ ☐ Stroke
- ○ ☐ Difficult breathing
- ○ ☐ Swelling of ankles
- ○ ☐ Cancer
- ○ ☐ Itching
- ○ ☐ Varicose veins
- ○ ☐ Bed Wetting
- ○ ☐ Kidney infection/stone
- ○ ☐ Prostate trouble
- ○ ☐ Cramps or backache
- ○ ☐ HIV or Hepatitis
- ○ ☐ Irregular cycle
- ○ ☐ Excessive flow
- ○ ☐ Diabetes
- ○ ☐ Difficult chewing
- ○ ☐ Blurred vision
- ○ ☐ Ear aches

Tingling or Numbness

- ○ ☐ Shoulders ○ ☐ Hips
- ○ ☐ Arms ○ ☐ Legs
- ○ ☐ Elbows ○ ☐ Knees
- ○ ☐ Hands ○ ☐ Feet

HABITS

	Heavy	Moderate	Light	None
Alcohol				
Coffee				
Tobacco				
Drugs				
Exercise				
Sleep				
Appetite				

Current medications:_____

_____

Do you take vitamins or minerals? _____

Do you think that you need vitamins or minerals?_____

Are you wearing: Heel lifts_____ Sole lifts_____

Inner soles____ Arch Supports_____

Please Complete Other Side

What operations have you had in the past?_____

Have you had any serious accidents? Describe_____

Have you had any serious illnesses? Describe_____

Financial Agreement

Name of person responsible for payment_____

Method of payment: Cash_____ Insurance_____Visa/Mastercard_____ Other_____

INSURANCE COMPANY: Please give your insurance card to the receptionist to copy for your file.

Primary Insurance _____ Address _____

Group #_____ Membership # _____

Secondary Insurance _____ Address

Group # _____ Membership # _____

Payment is expected at time of visit, unless other arrangements are made.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collections from the insurance carrier and that any amount authorized to be paid directly to this chiropractic office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immediately due and payable and that interest is charged at the rate of 1.5% percent per month (18% per annum) on those amounts 60 days and over. I further authorize and allow Dr. James E. Hollingsworth, associates, and his staff to perform necessary tests and to render appropriate chiropractic care, clinical hypnosis, and counseling.

Patient's signature_____ Date_____

Information taken by_____ Date_____