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 - Minor

Please fill out completely

Date: _____

Name_____ Social Security #_____ Home Phone_____

Address_____ City_____ State_____ Zip_____

School_____ Grade _____ Birthdate_____ Age _____

Father's Name_____ Birthdate _____ Soc. Sec. #_____ Phone_____

Employer_____ Occupation_____ Employer's Address_____

Mother's Name_____ Birthdate _____ Soc. Sec. #_____ Phone_____

Employer_____ Occupation_____ Employer's Address_____

Referred by _____ Address_____ City/Zip _____

Previous Chiropractic Care? Yes / No Physician's Name_____

Purpose of this appointment (major complaint)_____

Did this condition arise from your employment or at school?_____ Date of onset of your symptoms:_____

What do you believe is wrong with you?_____

What activities aggravate this condition?_____

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

Is this condition interfering with your: School/Work__ Sleep__ Daily Routine__ Other_____ Days lost from school/work _____

Other physicians seen for this condition_____

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

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

- ○ ☐ 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_____

Parent or Guardian's signature_____ Date_____
(authorizing care and guaranteeing payment)

Information taken by _____ Date_____