Holland Family Chiropractic Center Welcomes You!

New Patient Information

Name: ______________________________ Date of Birth: ____/____/_____ Social Security: ____-____-____
Address: ________________________________ City: ________________ State: _______ Zip: ___________
Home: (_____) ______-________ Work: (_____) _______-________ Cell Phone: (_____) _______-__________
Employer Name: ______________________________ Occupation: ______________________________
Spouse's Name: ______________________________________Number of Children: __________________
Referred to Holland Family Chiropractic by: ____
Have you received Chiropractic care before? __________ If yes, please indicate when and where: ____________
____

Insurance Information

Name of Health Insurance: ____________________________ Ins. Phone Number: _____________________
Policy Number: ______________________________Group Number: _______________________________

Briefly state your health complaint (s) and/or symptoms: ____
____
____
____

Please circle (Y) for yes and (N) for no for the following items:

Have you seen any doctors for your current problems? Y N
Have you been hospitalized for any current problems? Y N
Have there been any changes in your bodily functions (i.e. urination, bowel habits, respiration, digestion, vision, sexual function, other)? Y N
Please explain: ____
Have you found anything that makes your problem better (i.e. rest, morning, evening, certain positions)? Y N
Please explain: ____
Have you found anything that makes your problem worse (i.e. positions, activities, morning, evening, coughing, sneezing, staining when you move your bowels, other)? Y N
Please explain: ____
Does your condition/pain awaken you from your sleep? Y N
Please explain: ____
Does your condition/pain affect your work activities? Y N
Please explain: ____
Have you had time loss from work or school? Y N
Please explain: ____
Do you have any congenital (born with) factors which relate to your condition? Y N
Please explain: ____
Are you suffering from any conditions and/or disabling conditions other than those you are consulting us for?
Please explain: ____
What medications or drugs are you currently taking and for what reason (s)? ___________________________
____
Do you have a family history of any of the following conditions? If so, please circle.

Diabetes Heart Kidney Cancer Back Stroke Arthritis
____
____

Place a "B" if you have experienced any of the following BEFORE, an "N" if you are experiencing any of the following NOW, or "B&N" if both apply. Circle "R" for right and "L" for left, when appropriate.

____ Headache	____ Ringing in ears	____ Low blood pressure	____ Tailbone problems	____ Diabetes/Insulin Dependent Y / N
____ Behind Ears	____ Poor vision	____ Respiratory problems	____ Sacroiliac problems	____ Cancer
____ Forehead	____ Eye problems	____ Asthma	____ Poor circulation	Where: ____________
____ Temples	____ Sinus problems	____ Stroke	____ Cold hands	What type: __________
____ Migraine	____ Nasal problems	____ Breast problems	____ Cold feet	____ Polio
____ Pressure	____ Thyroid problems	____ Stomach problems	____ Loss of grip	____ Alcoholism
____ Head feels heavy	____ Throat problems	____ Ulcers	____ Swelling	____ AIDS
____ Loss of memory	____ Frequent colds	____ Digestive problems	Where:____________	____ Syphilis
____ Light-headed	____ Low resistance	____ Hernias (Chital, Inguinal, etc.)	____ Swollen joints	____ STD's
____ Fainting	____ Nervousness		Where: ____________	What type: __________
____ Dizziness	____ Depression	____ Gall bladder problems	____ Leg cramping	____ Mental disorder
____ Fatigue	____ Convulsions	____ Colon problems	____ Foot cramping	____ Bone disease
____ Weakness	____ Epilepsy	____ Constipation	____ Arthritis	____ Arteriosclerosis
____ Blurred vision	____ Nausea	____ Diarrhea	Where: ____________	____ Pacemaker
____ Light bothers eyes	____ Vomiting	____ Kidney problems	____ Rheumatoid Arthritis	____ Breast alterations
____ Loss of consciousness	____ Speech problems	____ Urinary problems	____ Psoriatic Arthritis	____ Plastic surgery
____ Loss of smell	____ Loss of weight	____ Hemorrhoids	____ Osteoporosis	____ Hip replacement
____ Loss of taste	____ Chest pain	____ Liver problems	____ Bursitis	____ Artificial joint
____ Loss of balance	____ Rib pain	____ Menstrual problems	____ Psoriasis	____ Diet controlled
____ Loss of hearing	____ Heart problems	____ Female organ problems	____ Muscle disease	Pregnant? Y / N
____ Ear problems	____ High blood pressure	____ Prostate problems	What type:__________	

Pain in:		Numbness		Pins & Needles		Neck	Mid-Back	Low-back
____ Arms	R L	____ Arms	R L	____ Arms	R L	____ Pain	____ Pain	____ Pain
____ Hands	R L	____ Hands	R L	____ Hands	R L	____ Spasm	____ Spasm	____ Spasm
____ Knees	R L	____ Legs	R L	____ Legs	R L	____ Stiffness	____ Stiffness	____ Stiffness
____ Legs	R L	____ Feet	R L	____ Feet	R L	____ Grinding	____ Grinding	____ Grinding
____ Feet	R L					____ Popping	____ Popping	____ Popping
____ Hips	R L					____ Pinched Nerve	____ Pinched Nerve	____ Pinched Nerve

Indicate if you have had any of the following: Please explain and give dates:

Accidents, falls, or injuries: ____

Broken bones/dislocation: ____

Spinal surgeries: ____

Other surgeries/operations: ____

Spinal injections: ____

Physical therapy treatments: ____

X-rays performed: ____

Doctor visits: ____

Hospital visits or stays: ____

Please list any additional comments you wish to make regarding your condition: ____________________
____

How do you want us to handle your problem?

Temporary relief _______ Maximum corrections ________

Payment is due at the time of service.

It is understood and agreed that the amount paid to Holland Family Chiropractic Center for x-rays is for evaluation only and x-ray negatives will remain property of this office.

Patient Signature: ________________________________ Date: _____/_____/__________