

Patient Information

Last Name _____
First Name _____
Middle Name _____
Address _____
City _____
State _____ Zip _____
Home Phone () _____
Work Phone () _____
SS# _____
Birth Date _____
Marital Status _____
Email Address _____
Name of Insured _____

Address _____
Home Phone () _____
Birth Date _____
SS# _____
Relationship to Patient _____

For Insurance Purposes:

Employer _____
Address _____
City _____
State _____ Zip _____
Employer Phone _____

Primary Insurance Company

Name _____
Address _____

Phone () _____
ID# _____

Secondary Insurance Company

Name _____
Address _____

Phone () _____
ID# _____

Have you suffered from:

- | | | |
|--|---|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Pins and Needles in Legs |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Pins and Needles in Arms |
| <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Depression | <input type="checkbox"/> Numbness in Toes |
| <input type="checkbox"/> Stiff Neck | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Numbness in Fingers |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Mid-back Pain | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Cold Feet |
| <input type="checkbox"/> Low-back Pain | <input type="checkbox"/> Loss of Sleep | <input type="checkbox"/> Cold Hands |
| <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Pain Down Legs | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Tight Muscles | <input type="checkbox"/> Head seems too Heavy | <input type="checkbox"/> Irritability |

Height: _____ Weight: _____

Major Complaint _____

When did it start? _____ Other Doctors seen for this Condition _____

Operations on you Neck or Back? yes no When? _____ Female- Are you Pregnant? _____

List any medications you are taking _____

Have you ever been to a Chiropractor before? yes no If yes, who? _____

Primary Care Physician _____ Phone () _____

May we contact him or her regarding your care? yes no

How did you hear about Holmes Chiropractic?

Newspaper Telephone Book Internet

Other _____ Referred by _____

Signature _____

Date _____