

# \_\_\_\_\_  
Date \_\_\_\_\_

## HOLLY SPRINGS CHIROPRACTIC CONFIDENTIAL PATIENT INFORMATION

**Welcome to Holly Springs Chiropractic, P.A.!** Please complete the following forms **COMPLETELY** and **ACCURATELY**. Your answers will help determine if chiropractic care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. If you need help, please ask us.  
This information will be held in the strictest confidence.

How did you hear about our office? \_\_\_\_\_

**Patient Data:**

Name: Mr. Mrs. Miss. Ms. \_\_\_\_\_ Prefer to be called: \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Email Address \_\_\_\_\_  
SS# \_\_\_\_\_ Drivers License # \_\_\_\_\_ DOB \_\_\_\_\_ Sex \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Best number to reach you: Home Work Cell Email  
People or Voicemails authorized to receive private health information including appointment reminder calls: \_\_\_\_\_  
Marital Status: Single/Married/Divorced/Widowed Spouse's Name: \_\_\_\_\_  
In case of Emergency Contact \_\_\_\_\_ Phone# \_\_\_\_\_

**Present Complaint:**

What are your symptoms? \_\_\_\_\_  
On a scale of 0 (no pain) to 10 (worst pain) please rate how you feel today: 0 1 2 3 4 5 6 7 8 9 10  
How long have you had this condition? \_\_\_\_\_ Years/Months/Days Have you had similar symptoms in the past? Y/N  
If yes, please explain \_\_\_\_\_  
How often does it occur? \_\_\_\_\_ Occasionally \_\_\_\_\_ Frequently \_\_\_\_\_ Constantly  
Since your symptoms began, are you getting: Better \_\_\_\_\_ Worse \_\_\_\_\_ No Change  
Does your condition interfere with your: \_\_\_\_\_ Work \_\_\_\_\_ Sleep \_\_\_\_\_ Daily Routine \_\_\_\_\_ Other  
What were you doing when you first noticed your symptoms? \_\_\_\_\_  
What makes you feel worse? \_\_\_\_\_  
What have you done to ease the discomfort? \_\_\_\_\_  
What other doctors have you seen for this condition? \_\_\_\_\_

**History:**

Have you ever been to a Chiropractor? Y/N If so, where? \_\_\_\_\_  
Are you taking any medications? Y/N If so, which? \_\_\_\_\_  
Have you ever been hospitalized? Y/N Why? \_\_\_\_\_  
List any surgeries and dates: \_\_\_\_\_  
Who is your family physician? \_\_\_\_\_ Phone # \_\_\_\_\_  
Date last seen \_\_\_\_\_ Reason \_\_\_\_\_  
Have you ever been in an automobile accident? Y/N Please describe: \_\_\_\_\_  
Any other traumas? \_\_\_\_\_ List any allergies \_\_\_\_\_  
Do you smoke? Y/N How much? \_\_\_\_\_ Do you drink alcohol? Y/N How much? \_\_\_\_\_  
Do you take any vitamin supplements? Y/N Which? \_\_\_\_\_ Do you wear heel lifts or orthotics? Y/N  
What type of physical activity do you do? \_\_\_\_\_ How often? \_\_\_\_\_  
Is there anything else you would like us to know? \_\_\_\_\_