

8 Dimensions Chiropractic & Acupuncture

Drs. Russ Hollinger, DC & Brook Hollinger, OMD

Name _____

Address

City _____ State _____ Zip _____ Home phn _____ Cell
phn _____

Pager _____ E-mail Home: _____ E-mail Work:

CCN _____ Date of Birth _____ Age _____ Height _____
What is the name of your family physician? _____ What city are they located
in? _____

Have you ever been to a Chiropractic doctor? _____ If yes, doctor name: _____ Date
of last visit _____

If you are experiencing any health problems, please list your chief complaints in order of severity
(pain, symptoms, etc.)

1. _____ For how long?

2. _____ For how long?

3. _____ For how long?

4. _____ For how long?

Has this problem been getting worse or staying the same?

_____ Currently or in the past have you

Have you ever had any surgeries or hospitalizations? _____ If yes, please list:

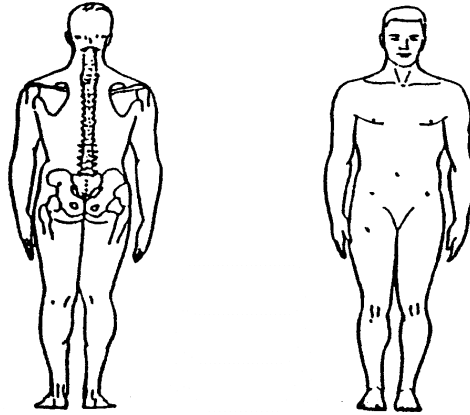
_____ Please list any current or past injuries and illnesses not listed above:

Health Insurance Co. Name _____ Policyholder

_____ Name of Spouse's health insurance (If applicable) _____ Policyholder

If you are experiencing any health problems, please mark the exact location of your pain on the diagram below. Also describe the type and frequency of your pain. For example, dull, sharp, constant, off and on, when standing, sitting, walking etc.

COMPLETE THESE DIAGRAMS



Method of payment for today's charges: CASH CHECK CREDIT
CARD _____

NOTICE: NOT ALL PATIENTS REQUIRE X-RAYS TO DETERMINE TYPE OF CARE AND LENGTH OF CARE. IF YOUR EXAMINATION WARRANTS X-RAY ANALYSIS, THE FOLLOWING OFFICE POLICY PREVAILS:

1. All first visit charges are payable when services are rendered.
2. The fee paid for x-rays is for analysis only. California State Law requires we maintain your x-rays. The film itself is the property of this office. Films may be loaned to another facility with authorization only.

Patient's Signature

Date
