

Today's Date [ / / ] Signature of Patient \_\_\_\_\_

Patient Title: (check one)  Mr.  Mrs.  Ms.  Miss  Dr.  Prof.  Rev.

First Name \_\_\_\_\_ Nick Name \_\_\_\_\_

Last Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Suffix \_\_\_\_\_

Address 1 \_\_\_\_\_

Address 2 \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Primary Phone \_\_\_\_\_ Secondary Phone \_\_\_\_\_

Home Email \_\_\_\_\_ Work Email \_\_\_\_\_

By providing my email address, I authorize my doctor to contact me via the email address(es) provided.

I choose to decline receipt of my clinical summary after every visit (These summaries are often blank because of the nature and frequency of chiropractic care.)

Date of Birth [ / / ] Age \_\_\_\_\_ Gender (check one)  Male  Female  Unspecified

Social Security Number \_\_\_\_\_

Employment Status (check one)

Employed  FT Student  PT Student  Other  Retired  Self Employed

Employer: \_\_\_\_\_ Employer Phone: \_\_\_\_\_

Marital Status (check one)  Single  Married  Other

Spouse's Name: \_\_\_\_\_ Spouse's Date of Birth: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Spouse's Employer Phone: \_\_\_\_\_

Race (check one)

White  Black/African American  Hispanic  American Indian/Alaskan Native
 Asian  Asian Indian  Chinese  Filipino
 Japanese  Korean  Vietnamese  Native Hawaiian or other Pacific Island
 Samoan  Guamanian or Chamorro  Other \_\_\_\_\_  I choose not to specify

Multi-Racial (check one)  Yes  No  Unknown

Ethnicity (check one)  Hispanic or Latino  Not Hispanic or Latino  I choose not to specify

Preferred Language (check one)

English  Spanish  American Sign Language  Chinese  French  German
 Tagalog  Vietnamese  Italian  Korean  Russian  Polish
 Arabic  Portuguese  Japanese  French Creole  Greek  Hindi
 Persian  Urdu  Gujarati  Armenian  I choose not to specify

New Patients Only: Whom may we thank for referring you? \_\_\_\_\_

Continued ...

Patient Name \_\_\_\_\_

**Verification Question** (choose only one question by circling the question, then give the answer to that question)

- What is the name of your favorite pet?    In what city were you born?    What high school did you attend?  
 What is your favorite movie?    What is your mother's maiden name?    On what street did you grow up?  
 What was the make of your first car?    When is your anniversary?    What is your favorite color?

**Verification Answer to the Chosen question:** \_\_\_\_\_ *Answers must be at least 6 characters.*

**Do you currently smoke tobacco of any kind?**    Yes    Former smoker    Never been a smoker

*If yes, how often do you smoke:*    Current every day smoker    Current sometimes smoker

*If yes, what is your level of interest in quitting smoking?*

- 0    1    2    3    4    5    6    7    8    9    10  
*No interest* *Very Interested*

**Current medications, *including dosage and frequency* if known.**

If there are no current medications, check here:

	Dosage & Start Date		Dosage & Start Date
1) _____		5) _____	
2) _____		6) _____	
3) _____		7) _____	
4) _____		8) _____	

**List any known allergies you have had to any medications. Please note the reaction and approximate reaction date.**

If no allergies are known, check here:

1) \_\_\_\_\_ reaction \_\_\_\_\_ year   3) \_\_\_\_\_ reaction \_\_\_\_\_ year  
2) \_\_\_\_\_ reaction \_\_\_\_\_ year   4) \_\_\_\_\_ reaction \_\_\_\_\_ year

**Briefly list your main health problems:** \_\_\_\_\_

**Has any doctor diagnosed you with Hypertension presently?**    Yes    No   If yes, describe: \_\_\_\_\_

**Has any doctor diagnosed you with Diabetes presently?**    Yes    No   If yes, what kind?    Type I    Type II

*If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%?*    Yes    No    Not Sure

*If yes, other comments regarding Diabetes:* \_\_\_\_\_

**Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days?**    Yes    No

**To be performed by clinic staff:**

**Height:** \_\_\_\_\_ inches   **Weight:** \_\_\_\_\_ pounds   **Pulse:** \_\_\_\_\_   **BP:** \_\_\_\_\_ / \_\_\_\_\_   **Lab**