Family Chiropractic Center

Today's Date: _____ Signature of Patient: _____

Social Security Number _____

First Name_____ **Nick Name**_____

Last Name_____ **Middle Name**_____ **Suffix**_____

Mailing Adress_____

City_____ **State**_____ **Zip Code**_____

Home Phone_____ **Work Phone**_____ **Mobile Phone**_____

Email Address you wish us to use to communicate with you: _____

Contact Method (check one) How I prefer to be contacted:

Home Phone_____ Work Phone_____ Mobile Phone_____

Date of Birth_____ Age_____ **Gender** (check one) Male_____ Female____ Unspecified____

Marital Status (check one) Single_____ Married_____ Other_____

Race (check one) White____ Black/African American_____ Hispanic_____ American Indian/Alaskan Native_____

Asian____ Japanese____ Native Hawaiian/ Pacific Island_____ Other_____ I choose not to specify____

Multi-Racial (check one) Yes_____ No_____ Unknown_____ I choose not to specify_____

Ethnicity (check one): Hispanic or Latino_____ Not Hispanic or Latino_____ I choose not to specify_____

Preferred Language: English____ Spanish____ Other_____ I choose not to Specify____

Payment Method (check one) Insurance_____ No Insurance_____

Employment Status (check one) Employed_____ Self Employed_____ Student_____ Retired_____

Employer_____ **Type of Work**_____

Employer Address _____

City_____ **State**_____ **Zip** _____

Spouse/Partner/Parents Information: (circle which applies)

Name_____ **Date of Birth**_____

Employer_____ **Type of Work**_____

Employer Address_____

City_____ **State**_____ **Zip**_____

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

Verification Answer to the Chosen question: _____

Do you currently smoke tobacco of any kind? _____Yes _____Never been a smoker _____Former smoker

If yes, How often do you smoke: _____Current Everyday smoker _____Current Someday smoker

How many packs per day _____ How many years have you smoked _____

If yes: What is your level of interest in quitting smoking? 0 1 2 3 4 5 6 7 8 9 10 N/A

List current medications including dosage, if known. If no medications are currently taken then check here:____

Medication Dosage Problem Treated

1)_____

2)_____

3)_____

4)_____

5)_____

6)_____

7)_____

8)_____

List any known allergies that you have to any medications. If no allergies are known then check here: _____

1)_____ **2)** _____

3)_____ **4)** _____

What are your main health problems? Briefly list the name of your problem(s), in order of importance:

Has any doctor diagnosed you with Hypertension presently? ___ Yes ___No If yes, what kind? _____

Has any doctor diagnosed you with Diabetes presently? ___ Yes ___No If yes, what kind? Type I or II ?

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? Yes__ No __ Not Sure___

Has any doctor diagnosed you with any type of significant health syndrome presently? Yes__ No__ Not Sure___

If yes, what kind? _____

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