Patient Data

Today's Date _____ Signature of Patient_____

Patient Title: __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 _____

Mobile Phone _____

Home Email _____ Work Email_____

Contact Method (check one)

__ Primary Phone __Secondary Phone __Mobile Phone __Home Email __Work Email

SSN_____ Gender: __Male __Female

Date of Birth _____

Employment Status (Check one) __Employed __FT student __PT student __Other

Marital Status (Check one) __Single __Married __Other

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
__Samban __Guamanian or Chamorro __ I choose not to specify __Other _____

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 __French Creole __Japanese __Greek __Hindi
__Persian __Urdu __Gujarati __Armenian __I choose not to specify

Verification Question (chose only 1 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 (must be at LEAST 6 characters): _____

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List any known allergies you have to MEDICATIONS.
__NO known medication allergies.

1)_____ 2)_____

3)_____ 4)_____

Briefly list other allergies:_____

_____

List current medications you are taking, including frequency and dosage if known.
__NO current medications

Medication	Dose	Quantity/Frequency	Date Started
Ex: Advil (Ibuprofen)	200 mg tabs	1 tab, 2x daily	~ 2 weeks ago

1)_____

2)_____

3)_____

4)_____

5)_____

Briefly List your Main health problems:_____

_____

Has any doctor diagnosed you with Hypertension? __Yes __No

If yes, describe:_____

Has any doctor diagnosed you with Diabetes? __Yes __No

If yes, what kind? __Type 1 __Type II

If yes, 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, CT scan or MRI of you LOW BACK in the past 28 days? __Yes __No

Do you currently smoke tobacco of any kind? __Yes __Former Smoker __Never been a smoker

If yes, how often do you smoke __Currently everyday smoke __Currently sometimes smoker

If yes, what is your level of interest in quitting? (0-10, 0=no interest, 10= very interested) _____

To be preformed by clinic staff:

Height:_____inches Weight:_____lbs BP:_____