

## Welcome To the Practice!

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Today's Date

First Name \_\_\_\_\_ Middle Name \_\_\_\_\_

Last Name \_\_\_\_\_

Address \_\_\_\_\_

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

Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Email \_\_\_\_\_

Whom May We Thank For Referring You? \_\_\_\_\_

Date of Birth  Age \_\_\_\_\_

Briefly describe what brought you here today: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How intense is your pain? (none) 0 1 2 3 4 5 6 7 8 9 10 (severe)

List current medications, including frequency and dosage if known. If there are no current medications, check here:

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

List any known allergies you have had to any medications.  
If no allergies are known, check here:

1) \_\_\_\_\_ 3) \_\_\_\_\_  
2) \_\_\_\_\_ 4) \_\_\_\_\_

Do you take vitamins; use nutritional supplements, herbs or homeopathic remedies? Please list. \_\_\_\_\_  
\_\_\_\_\_

**FOR CLINIC STAFF USE ONLY: PATIENT DOES NOT NEED TO COMPLETE THIS SECTION**

**Marital Status** (check one)  Single  Married  Other

**Employment Status** (check one)

Employed  FT Student  PT Student  Other  Retired  Self Employed

**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

**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?

**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*

**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

Primary Care Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

**To be performed by clinic staff:** Pulse Ox: \_\_\_\_\_ Heart Rate: \_\_\_\_\_

Height: \_\_\_\_\_ inches Weight: \_\_\_\_\_ pounds BP: \_\_\_\_\_ / \_\_\_\_\_