Christensen Chiropractic Clinic, P.C.

Patient Information Form

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

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**