R. Kim Etheredge, D.C.
Michael J. Paulk, D.C.

Daniel L. Wymer, D.C.
Higinio B. Serra, Jr., M.D.

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________________________

Mobile Phone________________________

Home email__________________________ **Work email**_____________________________

Preferred Contact Method (check one)

Primary Phone___ Secondary Phone___ Mobile Phone___ Home Email___ Work Email___

Date of Birth__________________ Age: _____

Gender (check one) Male____Female____Unspecified____

Marital Status (check one) Single____Married____Other____

Employment Status(check one)
Employed____ FT Student____ PT Student____ Other______ Retired____ Self Employed___

SSN____

Emergency Contact:

Name: ______________________________ **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___ Guamanian or Chamorro___ Samoen___ 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___ I choose not to specify___ Other_________

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 care? When is your anniversary? What is your favorite color?

Verification Answer to the Chosen question:

____

Email address that you prefer to have communication sent to you, from this office?

____

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

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

0	1	2	3	4	5	6	7	8	9	10	N/A

Not interested -------------------------> Interested

Who is your Primary Care Physician?

____

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

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):

____

____

____

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 spine in the past 28 days?
Yes ___ No ___ And what type and area scanned:______________________________

To be performed by clinic staff:

Height:____ ____Inches *Weight: ______pounds* *BP: ______/_______*

Is it okay to call you at work?

❑ Yes ❑ No

How did you hear about our clinic? Or who referred you?

❑ Family member	❑ Attorney	❑ Internet web site	❑ Health class
❑ Friend	❑ Yellow Pages	❑ Billboard	❑ Brochure
❑ Physician	❑ Newspaper ad	❑ TV Commercial	❑ Direct mail ad
❑ Employer	❑ Sign on building	❑ Radio	❑ Other

If you selected 'Yellow Pages' please indicate which Yellow Pages:

________________ ________________ ________________ ________________

If you selected 'family member', 'friend', or 'physician' please enter their name below:

____

If you selected 'other' please describe

____

Medical Conditions:

❑ Arthritis	❑ Cancer	❑ Diabetes	❑ Heart Disease
❑ Hypertension	❑ Psychiatric Illness	❑ Skin Disorder	❑ Stroke

Surgeries:

❑ Appendectomy	❑ Cardiovascular procedure	❑ Cervical disc procedure	❑ Hysterectomy
❑ Joint replacement	❑ Laminectomies	❑ Radical prostatectomy	❑ Transuretheral prostate surgery

Allergies:

❑ Eggs	❑ Fish and Shellfish	❑ Milk or Lactose	❑ Peanut
❑ Soy	❑ Sulfites	❑ Wheat/Gluten	

Social History:

❑ Caffeine used occasionally	❑ Caffeine used often	❑ Chew tobacco occasionally	❑ Chew tobacco often
❑ Drink alcohol occasionally	❑ Drink alcohol often	❑ Exercise not at all	❑ Exercise occasionally
❑ Exercise often	❑ Experience stress occasionall	❑ Experience stress often	❑ Smoke 1 pack or less per day
❑ Smoke more than 1 pack a day	❑ Wear seat belts always	❑ Wear seat belts never	❑ Wear seatbelts usually

Family History:

❑ Arthritis (parent)	❑ Arthritis (sibling)	❑ Cancer (parent)	❑ Cancer (sibling)
❑ Cholesterol (parent)	❑ Cholesterol (sibling)	❑ Diabetes (parent)	❑ Diabetes (sibling)
❑ Heart problems (parent)	❑ Heart problems (sibling)	❑ High blood pressure (parent)	❑ High blood pressure (sibling)
❑ Psychiatric (parent)	❑ Psychiatric (sibling)	❑ Stroke (parent)	❑ Stroke (sibling)
❑ Thyroid (parent)	❑ Thyroid (sibling)		

Substance Use:

❑ Alcohol (past)	❑ Alcohol (present)	❑ Amphetamines (past)	❑ Amphetamines (present)
❑ Barbiturates (past)	❑ Barbiturates (present)	❑ Cocaine (past)	❑ Cocaine (present)
❑ Crystal Meth (past)	❑ Crystal Meth (present)	❑ Heroine (past)	❑ Heroine (Present)
❑ Marijuana (past)	❑ Marijuana (present)		

Male Children:

❑ Under 6 years	❑ Under 10 years	❑ Under 19 years

Female Children:

❑ Under 6 years	❑ Under 10 years	❑ Under 19 years

Occupational Activities:

❑ Administration	❑ Business owner	❑ Clerical/secretarial	❑ Computer user
❑ Construction	❑ Daycare/childcare	❑ Executive/legal	❑ Food service industry
❑ Health care	❑ Heavy equipment operator	❑ Heavy manual labor	❑ Home services
❑ Household	❑ Light manual labor	❑ Manufacturing	❑ Medium manual labor