HAWTHORNE CHIROPRACTIC **ID#:_____ Date:_____**

_____WELCOME

PLEASE PRINT

First Name:_____ M.I.:_____ Last Name: _____Preferred Name:_____

Address:_____City:_____State:_____ZipCode:_____

Birthdate:____/____/_____Age:____Gender: M F Social Security #_____

Primary Phone:_____ Cell Phone:_____Work Phone:_____

Home Email:_____ Work Email:_____

By providing my email address, I authorize my doctor to contact me via the email address(es) provided.

Contact Method: (circle one) Primary Phone Cell Phone Work Phone

Status: (circle one) Single Married Divorced Widowed Separated

Spouse's Name:_____ Multi-Racial: (circle one) Yes No Unknown

Race: (circle one) White Black/African American Hispanic or Latino I choose not to specify

Ethnicity: (circle one) Hispanic or Latino Not Hispanic or Latino I choose not to specify

Preferred Language: (circle one) English Spanish Other_____

Occupation:_____ Employer:_____

Emergency Contact: _____ Phone Number:_____Relationship:_____

How were you referred to Hawthorne Chiropractic? Patient_____ Physician_____

(circle one) Yellow pages Internet Radio Newspaper Sign Other_____

Have you ever been diagnosed with <u>High Blood Pressure?</u> (circle one) YES NO

Have you ever been diagnosed with <u>Diabetes?</u> (circle one) YES NO

Have you ever <u>Smoked?</u> (circle one) Never Smoked Former Smoker Currently Smoke

Staff Will Fill in: **Height:_____ Weight:_____ BP_____ /_____**

Pulse:_____

List of current Medications, including dosage and frequency:

1_____ 6_____

2_____ 7_____

3_____ 8_____

4_____ 9_____

5_____ 10_____

List any known prescription drug allergies:

_____ _____

_____ _____

Surgeries and /or Hospitalizations (List and date)

_____ _____

_____ _____

_____ _____

List any immunizations and date: (example Flu Vaccine)

_____ _____

_____ _____

List any family history : (such as Diabetes, High Blood Pressure, Kidney Disease, Stroke, Heart Disease, or Heart Failure)

_____ _____

_____ _____

_____ _____

Do you drink alcohol?: (circle one) None Casual Beer Wine Moderate Drinker Heavy Drinker

Do you drink Caffeine?: (circle one) None < 3 drinks/day 3-6 drinks/day > 6 drinks/day

Do you use recreational drugs?: (circle one) Yes No

Do you exercise?: (circle one) Never Daily Weekly Walk Run Swim Other_____

Are you: (circle one) Employed Retired In School Un-Employed

If Retired, last occupation before Retiring_____

ACKNOWLEDGEMENT OF RECEIPT OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six (6) years.

_____ _____

Patient Name (please print) **Date**

_____

Parent, Guardian or Patient Legal Representative

_____

Signature

List below the names and relationship of people to whom you authorize the Practice to release Private Health Information:

_____ _____

_____ _____

_____ _____

_____ _____