Scituate and Burrillville Chiropractic Centers Inc.

Today's Date: _____ **Signature of Patient:** _____

Patient Title(check one) Mr. ___ Mrs. ___ Ms.___ Miss___ Dr. ___ Prof.___ Rev.___

First Name_____ **Middle Name**_____ **Last Name**_____ **Suffix**_____

Address _____ **City**_____ **State**_____ **Zip**_____

Primary Phone_____ **2nd Phone**_____ **Cell Phone**_____ **(Circle preferred)**

Home Email_____ **Work Email**_____,**(Check preferred)** Home____, Work____

Date of Birth_____ Age: ___ **Gender** (check one) Male____Female____

Marital Status (check one) Single____Married____Other____ **Employment Status:**

Employed____ FT Student____ PT Student____ Other___ Retired____ Self Employed___ **SSN**_____/_____/_____

Race (check one) White___, Black/African American___, Hispanic___ , Other____, I choose not to specify___

Ethnicity (check one): Hispanic or Latino___ Not Hispanic or Latino___ I choose not to specify___

Preferred Language (check one) English___ , Other_____, 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? What city were you born in? What is your favorite color?

Verification Answer to the Chosen question: _____

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

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 low back spine in the past 28 days? Yes ____ No ____

To be performed by clinic staff: Height:_____' _____" Weight: _____lbs BP: _____/_____