Patient Health History

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** _____

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

Which email address would you like us to use to communicate with you? *(check one)* ❑ Home ❑ Work

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 **SSN** _____

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	

Continued ...

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: _____

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 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) _____

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 <u>low back</u> spine in the past 28 days? ❑ Yes ❑ No

To be performed by clinic staff:

Height: _____inches **Weight:** _____ pounds **BP:** _____ / _____

Ryan Metivier, D.C.

Auburn Chiropractic- INTAKE FORM

21 Millett Drive
Auburn, ME 04210
P: (207)782-2600
F: (207)782-1331

Insurance - please allow our staff to photocopy your current health insurance card

- How did you hear about our office or who may we thank for referring you?_____
- Is your current condition the result of: ( )an auto accident? ( )a work related accident? Date of injury?_____
- Have you had previous chiropractic care? Y N ▪ If yes, what was the doctor's name?_____
- What was the approximate date of your last visit?_____ ▪ What was the duration of your care?_____

Please describe below your primary and additional reasons for seeking care in our office:

- Primary complaint:_____
- When did you experience this problem?_____
- How did this problem first begin?_____
- How often do you experience this problem? ( )1-2x/week ( )3-4x/week ( )5-6x/week ( )daily ( )other:_____
- Please grade the intensity of this problem? (Please make an X on the line to designate your answer)

At best: mild——————————————————————severe
At worst: mild——————————————————————severe

- How would you describe the symptoms (i.e. burning, stabbing, aching, sharp, etc.)_____
- Does this problem cause pain to travel to any other area? Y N If yes, where?_____
- Is this problem getting: ( )worse ( )better ( )staying the same?
- What seems to aggravate this problem?_____
- What have you tried to relieve this problem? (i.e. interventions, treatments, aspirin, medications, surgery)?_____
_____
- Have you seen any other doctors for this problem? Y N If yes, who?_____
- What treatment was given?_____
- How effective was the care?_____

- Date of last menstrual cycle:_____ ▪ Birth control pills? ( )Yes ( )No ▪ Are you pregnant at this time? ( )Yes ( )No

Consent for Treatment:
I, the undersigned, authorize the Doctor's of Auburn Chiropractic, and whomever they designate as their assistants, to perform diagnostic tests, including but not limited to x-rays, and to administer treatment as they deem necessary to me.

Patient's signature:_____ Date:_____

Consent for Treatment of a Minor: (If applicable)
I hereby authorize the Doctor's of Auburn Chiropractic, and whomever they designate as their assistants, to perform diagnostic tests, including but not limited to x-rays, and to administer treatment as they deem necessary to my (indicate relationship of child)_____, (child's name)_____.

Guardian's signature:_____ Date:_____