HUDAK CHIROPRACTIC CLINIC, P.C.

804 Elm Street, St Joseph, MI 49085 ◆ (269) 983-5527

Dear Patient, due to new guidelines starting October 1st 2011, we are required to update your demographics & health history once a year. Please complete the following form as thoroughly as possible to aid us in this. One of our CA's will also be updating your vital signs before you see the doctor.

Patient Demographics & Health History UPDATE

Patient Title: *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev.

First Name_____ **Last Name**_____

Address _____

City_____ **State**_____ **Zip Code** _____

Primary Phone _____

Text Appointment Reminders? ❑ Yes ❑ No **Mobile Phone**_____

Email _____

Your email address will be used to send Clinical Summaries. Verification question/answer required.

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: MINIMUM 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*

<u>Changes</u> to medications, including dosage if known:
If there are no current medications or any change to medications, check here: ❑

1) _____ **3)** _____

2) _____ **4)** _____

<u>Changes</u> to medication allergies:
If no allergies or changes are known, check here: ❑

1) _____ **2)** _____

Briefly list your current health problems (chiropractic and general medical problems**):**

_____

Has any doctor diagnosed you with Hypertension? ❑ Yes ❑ No

Has any doctor diagnosed you with Diabetes? ❑ Yes ❑ No If yes, what kind? ❑ Type I ❑ Type II

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