

Name: \_\_\_\_\_

2012

Date of Birth  /  /

Age \_\_\_\_

Gender (check one)  Male  Female  Unspecified

**Race (check one)**

- White  Black/African American
- Asian  Asian Indian
- Japanese  Korean
- Samoan  Guamanian or Chamorro
- Hispanic  American Indian/Alaskan Native
- Chinese  Filipino
- Vietnamese  Native Hawaiian or other Pacific Island
- Other \_\_\_\_\_  I choose not to specify

**Preferred Language (check one)**

- English  Spanish  American Sign Language
- Chinese  French  German
- Korean  Russian  Polish
- Arabic  Portuguese  Japanese
- French Creole  Greek  Hindi
- Persian  Urdu  Gujarati
- 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

**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?*

*No interest*  0  1  2  3  4  5  6  7  8  9  10 *Very Interested*

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

**Current medications, including dosage if known. If there are no current medications, check here:**

- 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) \_\_\_\_\_

In order to comply with the HITECH Act, we must demonstrate the capability to send patient health records electronically. We are connected with Microsoft ® HealthVault™, which is both secure and HIPPA compliant. To ensure your privacy when requesting electronic health records, we ask you to designate a verification question and answer, which will be used by HealthVault™ for identification purposes. We will periodically send an email containing a link to HealthVault™ so you can access your health records if you wish. If we do not have a Verification Question and Answer on file, we will not be able to send your health records via email.

**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 (must be longer than 6 characters):**

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**Email address:** \_\_\_\_\_

**Patient signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

<b>To be performed by clinic staff:</b> <b>Height:</b> _____ inches <b>Weight:</b> _____ pounds <b>BP:</b> ___ / ___
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