HARMON FAMILY CHIROPRACTIC

EHR / MU Patient Update Form _____ *DATE:* _____

Title: (check one) ☐Dr. ☐Mr. ☐Mrs. ☐Ms ☐Miss

First Name: _____ **Middle Initial:** _____ **Last Name:** _____
Nickname: _____
Address Line 1: _____
Address Line 2: _____
City: _____ **State:** _____ **Zip Code:** _____

Home Phone: (_____)_____-_____ **Work Phone:** (_____)_____-_____
Cell Phone: (_____)_____-_____ **Preferred Phone Contact Order (1,2,3): H___C___W___**
Date of Birth: _____/_____/_____ **Gender:** (check one) ☐Male ☐Female

Home Email: _____ **Work Email:** _____
Preferred Email Contact? ☐ Home ☐ Work ☐ Do not have Email
Social Security Number: _____-_____-_____ **Marital Status:** (check one) ☐Single ☐Married ☐Widowed ☐Divorced ☐Other_____

Employer Data (for Patient):

Name: _____
Address Line 1: _____
City: _____ **State:** _____ **Zip Code:** _____
Employment Status: (check one) ☐Employed FT ☐Employed PT ☐Retired ☐Unemployed ☐FT/PT Student ☐Other

Nationality/Race :

☐White/Caucasian ☐Black/African American ☐Hispanic/Latino ☐Chinese ☐Japanese ☐Other:___ ☐ I choose not to specify

Multi-Racial: (check one) ☐Yes ☐No ☐Unknown

Preferred Language: (check one) ☐ English ☐Spanish ☐Chinese ☐Japanese ☐ Sign Language ☐Other:_____

Health Records Verification Question: (Choose one question by checking a box, then give answer to that question)

☐ What is the name of your favorite pet? ☐ What city where you born in? ☐ What high school did you attend? ☐ What is your favorite movie?
☐ What is your mother's maiden name? ☐ What street did you grow up on? ☐ When is your anniversary? ☐ What is your favorite color?
Verification Answer to Chosen Question: _____

Primary Insurance Information

***Insured's Name:**_____
***Insured's Date of Birth:**_____
***Patient's Relationship to Insured:**_____
***Insurance Co. Name:**_____
***Insured's Social Security Number:** _____
Group # or Medicare # : _____
***Insured's Employer:** _____

Secondary Insurance Information

***Insured's Name:**_____
***Insured's Date of Birth** _____
***Patient's Relationship to Insured:**_____
***Insurance Co. Name:**_____
***Insured's Social Security Number:** _____
Group # or Medicare # : _____
***Insured's Employer:** _____

Emergency Contact

Contact Name:_____ **Relationship:**_____ **Contact Phone:** (_____) _____-_____

Family Physician Data

Name: _____
Address Line 1: _____ **Phone Number:**_____
City: _____ **State:** _____ **Zip Code:** _____

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CURRENT / PAST MEDICAL HISTORY UPDATE: Please check and/or list below, mark all that apply…

Describe your MAIN health problems, symptoms/areas of complaints: briefly list the name/nature of your problems

1._____

2._____

3._____

Has a doctor diagnosed you with any significant health syndrome presently? (check one) ☐Yes ☐ No ☐ Not sure

If yes, what kind? _____

Have you had an Xray, CT or MRI or other diagnostic test in the past 6 months? (check one) ☐Yes ☐ No
12 months?(check one) ☐Yes ☐ No

If yes, what test and where performed? _____

Current Medications: please check and list type or amounts ** ***If no medications are taken check here*** ☐

Please list *ALL* current medications including dosage if known.

1. Anxiety:_____ 2. Birth Control:_____ 3. Cholesterol:_____
4. Depression:_____ 5. Diabetes:_____ 6. Fibromyalgia:_____
7. Heart: _____ 8. High Blood Pressure:_____ 9. Inflammation:_____
10. MuscleRelaxer:_____ 11. Osteoporosis:_____ 12. Pain:_____
13. Thyroid:_____ 14. Other:_____ 15. Other:_____

List any known medication allergies that you have … ** ***If no medications allergies check here*** ☐

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

List and/or circle any other known allergies that you have... ** ***If no allergies check here*** ☐

1. Airborne Allergies:_____ 2. Eggs:_____ 3. Dust Mites:_____
4. Milk or Lactose:_____ 5. Molds:_____ 6. Peanuts:_____
7. Soy:_____ 8. Wheat/Gluten:_____ 9. Other:_____

Has a doctor diagnosed you with Hypertension/High Blood Pressure presently? (check one) ☐ Yes ☐ No

- If yes, what kind? ☐Essential/Primary ☐ Secondary ☐ Not sure

Has a doctor diagnosed you with Diabetes presently? (check one) ☐ Yes ☐ No If yes, what kind? Type I or II

- If yes, was your lab work test for hemoglobin A1c > 9.0%? ☐ Yes ☐ No ☐ Not sure

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Do you currently use tobacco of any kind? (check one) ☐Yes ☐ Never been a smoker ☐ Former Smoker

If yes, how often do you use tobacco and what kind:

☐ Cigarettes/Cigars ☐ Smokeless tobacco ☐ Current everyday ☐ Current occasional

What is your current level of interest in quitting smoking on a scale of 1-10 with 10 being a the highest desire to quit? (check one)

Patient/Guardian's Signature:_____ **Date:**_____

***To be performed by clinic staff*:** **Height** _____ ft, _____ in **Weight** _____ lbs

BP: _____ R / L seated - digital or manual