## PATIENT INFORMATION

LAST NAME: ____
FIRST NAME: ____

DATE OF BIRTH: ________

ADDRESS: ____________
ZIP, CITY, STATE: 96815, HONOLULU, HI

HOME PHONE:
CELL PHONE: ________
EMAIL: ________

**HOW DID YOU HEAR ABOUT US:**

[ ] DOCTOR: ____________________

[ ] PATIENT: ____________________

SOCIAL MEDIA: [ ] YELP [ ] GOOGLE [ ] FACEBOOK

MEDIA: [ ] MAGAZINE [ ] TV [ ] RADIO

OTHER: ____________________

**PRIMARY CARE DOCTOR'S INFO:**
NAME: ____________________
PHONE: ____________________

**PRIMARY PHARMACY INFO:**
LOCATION: ____________________
PHONE NUMBER: ____________________

**EMERGENCY CONTACT INFORMATION**
NAME: ____________________
RELATIONSHIP: ____________________
PHONE #: ____________________

**PRIMARY EMPLOYER INFORMATION:**
NAME: ____________________
PHONE:
EXTENSION: ____________________

RACE: [ ] American Indian or Alaskan Native [ ] Asian [ ] Black or African American [ ] White
[ ] Native Hawaiian/Other Pacific Islander [ ] Declined to Specify [ ] Other: ____________________

ETHNICITY: [ ] Hispanic or Latino [ ] Not Hispanic or Latino [ ] Decline to Specify

PREFERRED LANGUAGE: [ ] English [ ] Japanese [ ] Spanish [ ] Other: ____________________

**WHAT IS YOUR REASON FOR VISITING US TODAY?**

**WHICH BODY AREA / AREAS OR CONDITION WOULD YOU LIKE TREATED?**

**WHAT ARE YOUR EXPECTATIONS AND/OR WHAT WOULD YOU LIKE TO SEE IMPROVED?**