

Electronic Health Records Intake Form

This form complies with CMS EHR incentive program requirements

First Name: _____ Last Name: _____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ Gender (Circle one): Male / Female Preferred Language: _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date (Optional): _____

Family Medical History (<i>Record one diagnosis in your family history and the affected</i>)				
Diagnosis (Spine/muscle Related) Write in below	Father	Mother	Sibling: (_____)	Offspring: (_____)
<i>Example:</i>	<i>Low back pain</i>	<i>Headaches</i>		

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (<i>Include regularly used over the counter medications</i>)	
Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?			
Medication Name	Reaction	Onset Date	Additional Comments

I choose to decline receipt of my clinical summary after every visit (*These summaries are often blank as a result of the nature and frequency of chiropractic care.*)

Patient Signature: _____ Date: _____

For office use only			
Height: _____	Weight: _____	Blood Pressure: _____ / _____	Pulse _____