

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 / Occasional / Former / Never

Smoking Start Date (Optional): _____

Family Medical History (Record one diagnosis in your family history and the affected) relative				
Diagnosis (Write in below) <i>Example: Heart Disease</i>	Father	Mother	Sibling: (_____)	Offspring: (_____)
		X		

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? (Include regularly used over the counter medications)	
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: _____ / _____