Electronic Health Records Intake Form

First Name: ___________________________ Last Name: __________________________________________

Address: ________________________________ City & State: ________________________________________

Phone #: ______________________________ Email Address: _______________________________________

DOB: _______________ Gender:___Male___Female Preferred Language: _________________________

Smoking status (check one)___Every day smoker___Occasional smoker___Former smoker___Never smoked

Smoking exposure (check one)___constant___occasionally___none

Family Medical History (record one diagnosis in your family history and check the affected)

Diagnosis: (ex: Heart Disease)

___________________________ ___Father___Mother___Sibling (__________)___Offspring (_____________)

Race (check one) ___ American Indian___Alaska Native___Asian___Black___African American___White (Caucasian)___Native Hawaiian or Pacific Islander___I Decline to answer

Ethnicity (check 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 (ex: Motrin, 5mg, once a day, etc.)

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

Do you have any medication allergies and reactions?

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

I choose to decline receipt of my clinical summary after every visit (these summaries are often blank as a result of the nature of chiropractic care) ___Yes___No

Patient Name (printed): ________________________________________________________________________

Patient Signature: ___________________________________________________ Date: ____________________

For office use only

Height: ________ Weight: __________ Blood Pressure: _____/______ Pulse: ___________