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: _____