Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

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): _____

CMS requires providers to report both race and ethnicity

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? (Please 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:_____ /_____

PATIENT APPLICATION FOR TREATMENT

General Information

Today's Date: _____ Account# _____

Name: _____

How would you like to be addressed: _____

Date of Birth: _____ Age: ____ Gender: M F

SS# _____

Home Address: _____ Home Phone: _____

_____ Cell Phone: _____

_____

Work Address: _____ Occupation _____

_____ Work Phone: _____

_____ Extension: _____

Email Address: _____

Emergency Contact: _____ Phone# _____

How did you hear about us? (circle one) Person's Name: _____

AT&T/DEX Yellow Pages Yellow Book First Choice Yellow Pages YellowPages.com

Internet Search Engine: Yahoo Google MSN Key Words Used: _____

Welcome Wagon Newslpaper Flyer Other _____

Family Information

Martial Status: S M W D Spouse Name: _____

How many children do you have? ____

Names: _____ Age: ____ Gender: M F

_____ ____ M F

_____ ____ M F

_____ ____ M F

Have they or any other member ever received chiropractic care? Y N

Personal Information

Have you ever had chiropractic care? Y N How long ago? ____

The reason for this appointment? _____

_____

_____

Patient: _____ Date: _____ Acct: _____

PATIENT HISTORY

How much water do you drink daily? _____

Do you drink alcohol? Y N How much? _____

Do you drink coffee? Y N How much? _____

Do you drink pop? Y N How much? _____

Do you smoke? Y N How many per day? _____ How long? _____

Do you exercise? Y N How often? _____ Type: _____

Do you have allergies? (Specify) _____

_____

Have you ever suffered or been diagnosed as having: (circle yes or no for each)

Y	N	Broken/Fractured Bones	Y	N	Osteoporesis	Y	N	Eating Disorder
Y	N	Circulatory Problems	Y	N	Epilepsy	Y	N	Alcoholism
Y	N	Rheumatoid Arthritis	Y	N	Pacemaker	Y	N	Drug Addiction
Y	N	Osteoarthritis	Y	N	Strokes	Y	N	HIV Positive
Y	N	Congenial Disease	Y	N	Cancer	Y	N	Sleep Disorder/Insomnia
Y	N	Excessive Bleeding	Y	N	Tumors/Fibroids	Y	N	High/Low Blood Pressure
Y	N	Seizures/Convulsions	Y	N	Diabetes	Y	N	Fibromyalgia
Y	N	Coughing Blood	Y	N	Ulcers	Y	N	Depression

If you marked yes to any of the above, please explain: _____

_____

_____

Have you ever been in a motor vehicle accident or had any traumas? If so, please describe:

_____

_____

_____

When was your last Physical Exam? _____ X-rays? _____

Medications

Name of Medication	Reason for Taking	Non Rx Strength	Rx Strength	Date Started	Date Stopped	Prescribed By
						Doctor Self
						Doctor Self
						Doctor Self
						Doctor Self
						Doctor Self

Are you taking any vitamins? Y N Types of vitamins: _____

_____

_____

Patient: _____ Date: _____ Acct: _____

PATIENT HISTORY

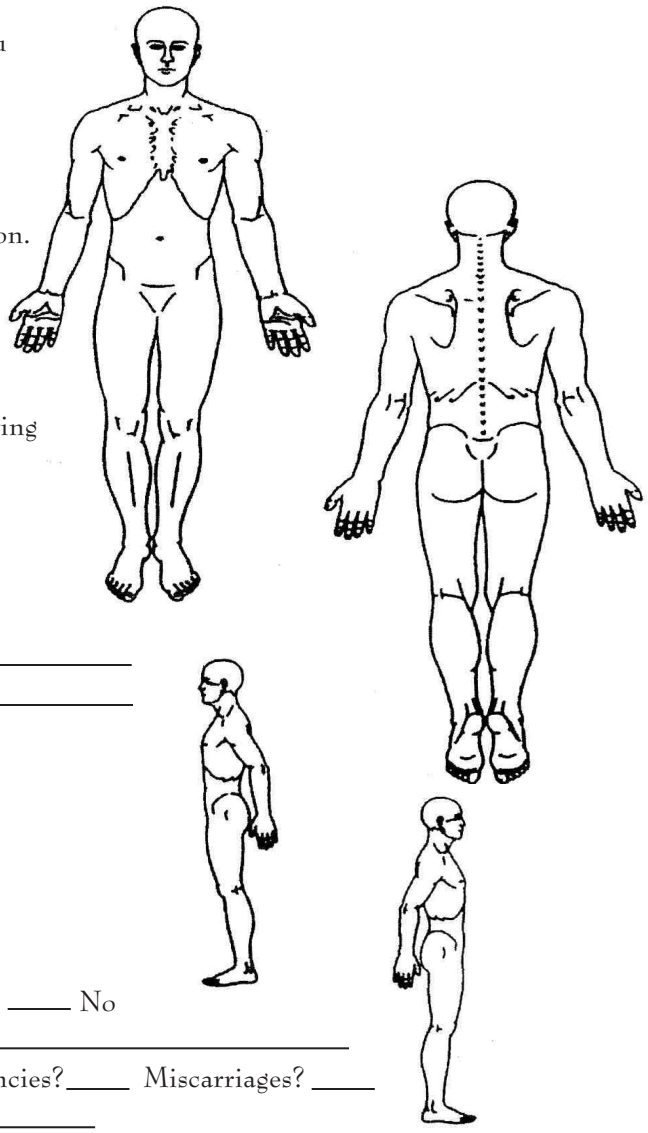
1. What is your main complaint? _____
2. On the scale below, please circle the **severity** of your **main complaint** (at its worst)

   None Slight Mild Moderate Severe
   0 1 2 3 4 5 6 7 8 9 10

3. On the scale below, please circle the **percentage of time** you experience your main complaint:

   Occasional Intermittent Frequent Constant
   0 10 20 30 40 50 60 70 80 90 100%

4. a. When did your symptoms first begin? _____
   ____ This is the first time I am experiencing this condition.
   ____ This is an exacerbation of a previous condition.
   b. What were you doing when your symptoms began?
   _____
5. On the diagram to the right, please show **where** you were experiencing **all** of the **present complaints** using the following letters:
   A: ache B: burning pain C: cramping D: dull pain
   R: throbbing pain N: numbness T: tingling
6. a. When do you notice it most? ____ AM ____ PM
   b. How long does it last? ____ Mins ____ Hrs
7. What makes it feel better? _____
8. What makes if feel worse? _____
9. I have been
   ____ hospitalized for this problem
   ____ treated by another chiropractor
   ____ treated by another specialty provider
   ____ not received care for this problem
10. Have you lost work time because of it? ____ Yes ____ No
    Dates: _____ to _____
11. Are you experiencing any other health concerns? ____ Yes ____ No
    Please explain: _____
12. Are you pregnant? ____Yes ____No Number of pregnancies?____ Miscarriages? ____
13. What was the first day of your last menstrual cycle? _____



Do you have **pain and/or difficulty** performing any of the following activities? (check all that apply)

- ____ Personal care/grooming
- ____ Lifting
- ____ Reading
- ____ Concentrating
- ____ Working
- ____ Driving
- ____ Sleeping
- ____ Recreational activities/hobbies
- ____ Walking
- ____ Sitting
- ____ Standing
- ____ Social activities

Patient Signature: _____ Date: _____

Patient: _____ Date: _____ Acct: _____

SYSTEMS REVIEW

Please indicate with a (C) conditions you have now or with a (P) the conditions that you have had in the past. If neither applies, mark NA. Please do not leave blanks.

_____ High Blood Pressure
_____ Dizziness/Fainting
_____ Insomnia
_____ Low Resistance
_____ Tension
_____ Confusion
_____ Fatigue
_____ Ulcers
_____ Eye/Vision Problems
_____ Ear/Hearing Problems
_____ Difficulty Breathing
_____ Heart Problems
_____ Loss of Bladder Control
_____ Constipation
_____ Diarrhea
_____ Digestion Problems
_____ Nausea
_____ Female Problems
_____ Prostate Problems
_____ Diabetes
_____ Hands/Feet Cold
_____ Hand Tremors
_____ Loss of Memory
_____ Nervousness
_____ Sweaty Palms
_____ Speech Difficulty
_____ Anxiety
_____ Depression
_____ Irritability

Please identify all facilities/providers you have seen for these conditions and those you are currently seeing, if any, for your presenting problem(s):

Doctor's Name/Facility	Surgery/Treatment	Procedure Received	Date(s) of Procedure

For Doctor's Use Only

Dr. Reviewed	Systems	Symptoms	Dr. Comments
	General	Weight changes, fatigue, anorexia, weakness, fever, changes in activity	
	Skin	Rashes, eruptions, changes in warts, moles, or pigmentation, bruising, itching, hair loss, nail changes	
	Head	Trauma, headaches, dizziness, light headed	
	Eyes	Changes in acuity in vision, use of corrective lenses, blurred vision, increased tearing, redness, discharge, pain	
	Nose	Rhinorrhea, epititis, allergies, airway obstruction	
	Mouth & Throat	Ulcers, tooth pain/extraction, TMJ pain, gum bleeding, soreness, swelling, enlarged glands, sore throat, strep	
	Neck	Stiffness, lumps/swelling/masses, pain	
	Lungs	Cough (productive/non productive), hempotysis, dyspnea, pain with respiration, wheezing, night sweats	
	Cardiac	Palpitation, chest pain, orthopnea, paroxysmal nocturnal dyspnea, ankle swelling, syncope	
	Vascular	Raynaud's phenomenon, intermittent claudication, hypertension, rheumatic fever	
	Breasts	Self-examination frequency/results, pain, nipple discharge, lumps/masses, skin, dimpling	
	Gastrointestial	Usual diet, regurgitation, dyspepsia, nausea, vomiting, belching, abdominal pain, cramps, hematemasis	
		Stool color changes, diarrhea, constipation, change in bowel habits, jaundice, abdominal swelling, BM frequency	
	Genitourinary	Polyuria, dysuria, urgency, stress incontinence, urine color changes, hematuria, STD, nocturia, hernia, scrotal mass	
	Endocrine	Polydispia, polyphagia, temp. intolerance, tremors, goiter, alopecia, dysmenorrhea, PMS, menstrual hx, pregnancy hx	
	Hemtopoietic	Anemia, abdominal bleeding, lymph node enlargement/pain	
	Musculskeletal	Bone/joint pain, swelling, joint deformity, trauma, restricted range of motion, weakness, atrophy	
	Neurological	Cranial nerve deficits, seizures, LOC, tremors, stasis, loss of balance, numbness, paresthesia	
	Psychological	Mood swings, depression, anxiety, phobias	

Doctor's Initials _____