Chiropractic Care Clinic – YEAR 2022

Electronic Health Records Intake Form Chart#\_\_\_\_\_\_\_\_\_\_

First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI\_\_\_\_\_ Last Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: Male [ ] Female [ ] Preferred Language:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sign up for Text reminders? Yes [ ] No [ ] Already Have [ ] Cell phone number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact/Relation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Existing Pts. Only – Address, Phone #, or Insurance Change:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Smoking Status: Never Smoked [ ] Every Day Smoker [ ] Occasional Smoker [ ] Former Smoker [ ]

Smoking Start Date (Optional):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Race: American Indian or Alaska Native [ ] Asian [ ] Black or African American [ ] White (Caucasian) [ ]

Native Hawaiian or Pacific Islander [ ] Decline to Answer [ ] Other [ ]\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ethnicity: Hispanic or Latino [ ] Not Hispanic or Latino [ ] Decline to Answer [ ]

Do you have any Medicine or Food or Environmental Allergies? Use back of form if necessary.

Allergy:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergy:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently taking any medicine? (For example, Lasix 20mg once daily) Use back of form if necessary.

Medicine Dosage Frequency Medicine Dosage Frequency

Specifically G.I. medications:

Family Medical History: (F-Father, M-Mother, B-Brother, S-Sister, or C-Child)

Heart Disease:\_\_\_\_\_\_\_\_\_\_\_ High Blood Pressure:\_\_\_\_\_\_\_\_\_\_\_ Diabetes:\_\_\_\_\_\_\_\_\_\_\_ Cancer:\_\_\_\_\_\_\_\_\_\_\_

Kidney Disease:\_\_\_\_\_\_\_\_\_\_ Lung Disease:\_\_\_\_\_\_\_\_\_\_ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] I choose to allow CCC to register clinical summary and set up my Patient Portal account.

Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*For Office Use Only –*

*Blood Pressure:\_\_\_\_\_\_/\_\_\_\_\_\_ Pulse\_\_\_\_\_\_\_ Dr.Kamerman\_\_\_\_\_\_\_Dr.Ward\_\_\_\_\_\_\_Staff\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*