Electronic Health Records Intake Form:

This form complies with CMS EHR Program Requirements

1001 Gornick Avenue
Gaylord, MI 49735
989-732-1533
989-732-0629 Fax

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): _____

Family Medical History: (*Record one diagnosis in your family history and the affected*)				
Diagnosis (Write it below)	Father	Mother	Sibling: (_____)	Offspring: (_____)
Example: Heart Disease				

Race (Circle one): American Indian or Alaska Native / Asain / 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 5 mg 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: _____/_____