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Electronic Health Records Intake Form

In compliance with requirements for the government CMS program

❒Male ❒Female Pregnant? ❒No ❒ Yes, due date? ___/___/___ **Social Security #** ___ ___ ___/___ ___/___ ___ ___ ___

Last Name_____ **Legal First Name**_____ **DOB:** ___/___/___

Preferred Name_____**Address**:_____
(City) (State) (Zip Code)

Home Phone: (____)____-_____ **Cell phone:** (____)____-_____ **Work phone:** (____)____-_____

Email address:_____

Occupation: _____ **Employer Name**: _____

Employer address: _____

Status: ❒ Single ❒ Married ❒ Divorced ❒ Widowed ❒ Legally Separated
Spouse Name: _____ **# of Children**: ___ **Names**: _____

Will an insurance company be <u>contributing</u> to your care? ❒No ❒ Yes *(If no, ask us about our wellness plans)*

Primary: _____ ***Secondary***: _____

Waiver: I authorize Fixen Chiropractic and my insurance company to process claims with my information. *(signature)*_____ *(date)* ___/___/___

Waiver: I authorize my insurance company to release data and to contribute to my care at Fixen Chiropractic. *(signature)*_____ *(date)*___/___/___

Waiver: I have been offered a copy of Fixen Chiropractic's *HIPAA HITEC consent*, and the following person(s) have permission to any and all of my records (if applicable).

_____

*(signature)*_____ *(date)* ___/___/___

Waiver: I understand that there are minimal risks with Chiropractic Care, Acupuncture, and Physiotherapies.

*(signature)*_____ *(date)* ___/___/___

How were you referred to Fixen Chiropractic? *(Check One)*

❒Patient _____ ❒Internet _____ ❒Location
❒Physician _____ ❒Radio ❒Other _____
❒Phone book _____ ❒Newspaper

Preferred Language: (*Fill in the Blank)* _____

My race is: *(Check One)*

❒American Indian/Alaska Native ❒Black ❒White
❒Asian ❒Pacific Islander ❒Other _____

My ethnicity is: (*Check One*)

❒ Hispanic or Latino ❒Not Hispanic or Latino

What is the major symptom/problem? _____

What were you doing when the condition started?_____

When did symptoms begin? _____

Have you had this problem before? ❒No ❒ Yes, when? _____

Is the condition getting progressively worse? ❒No ❒ Yes

Pain scale: (*please circle*) *No pain* **1 2 3 4 5 6 7 8 9 10** *Severe pain*

When do you feel your pain more? (*Check One*)

❒ Morning ❒ Afternoon ❒ Evening ❒ Night

How often do you experience pain? (*Check One*)

❒None of the time ❒1-25% ❒26-50% ❒51-75% ❒76-99% ❒Constantly

Does it cause problems elsewhere? ❒No ❒ Yes Where**?** _____

What makes the condition better? _____

What makes the condition worse? _____

What does it interfere with? *(Check all that apply)*

❒Sleep ❒Work ❒Housework ❒Routine ❒Recreation ❒Other_____

Is it painful to perform any of the following? *(Check all that apply)*

❒Sitting ❒Bending ❒Reading
❒Standing ❒Lying down ❒Getting up
❒Walking ❒Driving ❒Other_____

Have you had any traumas? *(check all that apply)*

❒Falls ❒Concussions ❒Broken bones
❒Head injuries ❒Auto Accidents ❒Other_____
❒ER visits ❒Work Comp injuries

Please briefly describe: _____

Have you been seen by a chiropractor in the past? ❒No ❒ Yes **When?** _____
Who? _____

Are you currently taking medications, prescription drugs, and pain killers? ❒No ❒Yes
(Please include regularly used over the counter medications)

Prescription Name	Dosage	Frequency	What is it for?

Please provide past medical visit information. *Example: Cholesterol, Glucose, Thyroid, Mammogram etc.*

Name	Date	Result
	___/___/____	
	___/___/____	
	___/___/____	

Have you had any surgeries? ❒No ❒Yes *If yes, please list below*

Type of Surgery	Date	What was it for?	Any reaction?	
	___/___/____		❒Yes	❒No
	___/___/____		❒Yes	❒No
	___/___/____		❒Yes	❒No

Please check all that apply to your health.

Ankylosing Spondilitis (M45.9) ❒	Tension Headaches (G44) ❒	IBS(K58) ❒/Crohn's (K50.90) ❒
Degenerative Disk Disease (M51, M50) ❒	Trigeminal Neuralgia (G50.0) ❒	Diverticulitis (K57.92) ❒
Facet Arthritis-Dorsopathy (M53) ❒	TMJ Disorder (M26.60) ❒	Diverticulosis(K57.90) ❒
Osteoarthritis-Extremity Joint-(M19) ❒	Vertigo (H81) /Dizziness(R42) ❒	Asthma (J45) ❒
Osteoporosis(M81.0)❒/Osteopenia ❒	Blood Pressure Issues ❒ High (I10) ❒Low (I95.0)	COPD (J44.9) ❒/ Emphysema (J43.9)❒
Psoriatic Arthritis (L40.9) ❒	Diabetes ❒ Type 1(E10.9) ❒Type 2 (E11.9) ❒Gestational (024.419)	Cystic Fibrosis (E84.9) ❒
Rheumatoid Arthritis (M06.9) ❒	Heart Attack (old-I25.2) ❒	Cerebral Palsy (G80.9) ❒
Scoliosis (M41) ❒	High Cholesterol (E78.5) ❒	Epilepsy (G40.9) ❒
Spondylolisthesis (M43) ❒	Thyroid Hypo(E03.9)❒/Hyper (E05.90) ❒	Multiple Sclerosis (G35) ❒
Spondylosis-Spine-DJD-(M47) ❒	Raynaud's Syndrome (I73.00) ❒	Parkinson's Disease (G20) ❒
Stenosis (M48.0) ❒	Poor circulation ❒	Stroke ❒/TIA❒
Arm Pain❒/Leg Pain ❒	Pace Maker ❒	Lupus ❒
Fibromyalgia (M79.7) ❒	Chronic Fatigue❒/Insomnia❒	Anxiety (F41.9) ❒/ Depression (F41.8) ❒
Sinus Infection ❒	Hepatitis ❒ A(B15.9) ❒ B(B19.10) ❒ C(B19.20)	Club Foot (Q66.89) ❒
Shingles (B02) ❒	Bladder Problems ❒	Gout (M1A/M1O) ❒
Headaches ❒	Kidney Stones ❒	Plantar Fasciitis(M72.2)❒/Foot Pain ❒
Cluster Headaches (G44) ❒	Irregular Cycle ❒	Other_____ ❒
Migraines (G43) ❒	Celiac's (K90.0) ❒	

Cancer

❒Liver (C22) ❒Pancreatic (C25) ❒Skin (C43/C44) ❒Prostate (C61) ❒Testicular (C62) ❒Uterine (C55) ❒Thyroid (C73)
❒Brain (C71) ❒Ovarian (C56) ❒Throat (C15) ❒ Breast (C50) ❒Colon (C18) ❒Lung (C34)
❒Other_____

Summary of your family history. *(Please check type and list whom)*

Cancer

❒Thyroid(C73)_____ ❒Liver(C22.9)_____ ❒Ovarian(C56.9)_____ ❒Prostate(C61)_____
❒Colon(C18.9)_____ ❒Lung(C34.90)_____ ❒Brain(C71.9)_____ ❒Skin(C43.9)_____
❒Testicular(C62.90)_____ ❒Uterus(C55)_____ ❒Pancreatic(C25.9)_____ ❒Throat(C15.9)_____
❒Breast(F-C50.919/M-C50.929)_____ ❒Other_____

Diabetes

❒Type 1(E10.9)_____ ❒Type 2(E11.9)_____

Heart Attack/Disease(I25.2) ❒_____

Blood Pressure

❒High(I10)_____ ❒Low(I95.0)_____

Scoliosis(M41.9) ❒_____

Stenosis(M48.00) ❒_____

Disc Disorder

❒Thoracic/Lumbar(M51.9)_____ ❒Cervical(M50.90)_____

Please provide the date of last appointment for the following:		**What part of the body?**
Medical Exam	Date: ___/___/____	_____
Spinal X-Ray/Exam	Date: ___/___/____	_____
MRI	Date: ___/___/____	_____
CT-Scan	Date: ___/___/____	_____

On a scale of 1 to 10, rate your stress level on a daily basis. (*Circle One*)

Least 1 2 3 4 5 6 7 8 9 10 *Most*

Smoking Status (*Check One*)

❒Every Day Smoker ❒Occasional Smoker ❒Former Smoker ❒Never Smoked

How many alcoholic drinks do you drink per week? *(Fill in the blank)*_____*per week*

How many caffeinated drinks do you drink per week? *(Fill in the blank)*_____*per week*

How do you perceive your weight? (*Check One)*

❒Obese ❒Normal weight ❒Underweight

❒Overweight ❒Slightly underweight

Are you interested in a *free* nutrition/weight loss consultation? ❒Yes ❒No

How do you think you eat? (*Check One)*

❒Not healthy ❒Somewhat healthy ❒Healthy

Have you ever been on a diet to lose weight? (*Check One)*❒Yes ❒No

If you answered yes above, have you ever had success with weight loss?❒Yes ❒No **If not, how come?**

❒Too hard ❒Not for me ❒Too many habits to break ❒Social life got in the way ❒Family eating habits ❒Traveled ❒Eating healthy is too expensive ❒No grocery store food choices

Are you currently taking supplements or vitamins? ❒No ❒Yes *If yes, please list below*

Supplement Name	Dosage	Frequency	What is it for?

Do you have any allergies? ❒No ❒Yes *If yes, please list below*

Allergy Name	Reaction	Onset date	Additional comments
		___/___/____	
		___/___/____	

Have you had any vaccinations and/or injections? ❒No ❒Yes *If yes, please list below*

Vaccine Name	Date	What was it for?	Any reaction?
	___/___/____		❒Yes ❒No
	___/___/____		❒Yes ❒No

Do you want a receipt of a clinical summary after every visit *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

❒ No, I **do not** want a summary receipt after every visit.

❒ Yes, I want a summary receipt even though it may be blank.

Patient Signature: _____ Date___/___/___

Office Use Only *HT:* *WT:* *lbs* *BP:* / *O2:* *Pulse:*

□*Verify info in CT* □*EHR Wizard* □*Alert* □*Doctor* □*Scan*