FELD FAMILY CHIROPRACTIC CENTER

126 W. MAIN STREET

ROCKAWAY, NJ 07866

ELECTRONIC HEALTH RECORDS INTAKE FORM

IN COMPLIANCE WITH REQUIREMENTS FOR THE GOVERNMENT EHR INCENTIVE PROGRAM

DATE _____

NAME _____ HOME PHONE _____ CELL _____

ADDRESS_____ CITY _____ STATE_____ ZIP _____

AGE _____ BIRTH DATE _____ MARITAL STATUS (CIRCLE ONE) S M W D

GENDER (CIRCLE ONE) M F PREFERRED LANGUAGE _____

(CM5 REQUIRES PROVIDERS TO REPORT BOTH RACE AND ETHNICITY)

RACE (CIRCLE ONE) AMERICAN INDIAN / ALASKA NATIVE / ASIAN / AFRICAN AMERICAN / BLACK / WHITE (CAUCASIAN) / NATIVE HAWAIAN/PACIFIC ISLANDER / OTHER _____ / LATINO / DECLINE TO ANSWER

ETHNICITY: (CIRCLE ONE) HISPANIC OR LATINO / NOT HISPANIC OR LATINO / OTHER _____/

I DECLINE TO ANSWER

HEIGHT _____ WEIGHT _____ DATE OF LAST PHYSICAL EXAM _____

NAME OF PRIMARY CARE PHYSICIAN _____ PHONE # _____

ADDRESS_____ CITY _____ STATE_____ ZIP _____

ARE YOU CURRENTLY TAKING ANY MEDICATION? (PLEASE INCLUDE REGULARLY USED OVER THE COUNTER MEDICATIONS)

NAME OF MEDICATION/DATE OF FIRST DOSAGE	DOSAGE AND FREQUENCY (I.E. 5 MG ONCE A DAY, ETC)

DO YOU HAVE ANY MEDICATION ALLERGIES:

MEDICATION NAME	REACTION	ONSET DATE	ADDITIONAL COMMENTS

LIST ANY OTHER ALLERGIES: (I.E. HAYFEVER, ETC) _____

LIST ALL SURGERIES AND DATE OF SURGERY _____

_____

SMOKING STATUS: (CIRCLE ONE) EVERYDAY OCCASIONAL FORMER NEVER HOW MANY PACKS A DAY _____

☐ I DECLINE TO REQUEST RECEIPT OF MY CLINICAL SUMMARY AFTER EVERY VISIT. (THESE SUMMARIES ARE OFTEN BLANK AS A RESULT OF THE NATURE AND FREQUENTCY OF CHIROPRACTIC CARE.)

PATIENT SIGNATURE _____ DATE _____