

Rizzo & Wiegeling Chiropractic
502 Logan Blvd.
Altoona, PA 16602
814-944-3536 Phone

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name: _____ Last Name: _____

Email address: _____@_____

Can we send you text reminders for appointments, etc? Y / N ? Cell #: _____

DOB: __/__/____ Gender (Circle one): Male / Female Preferred Language: _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

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 / Other / 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 Information

Name _____
First Middle Last

Birth date _____ Age _____ Sex [M F]

Address _____

Home Phone _____ Work Phone _____

City _____ State _____ Zip _____

Cell Phone _____ Ok to text you? Y / N

Insurance Company _____

Social Security # _____

Marital Status M W D S Spouse's Name _____

Employer Name _____

Children's Names _____

Occupation _____

What is your current problem/complaint? _____

Is this condition due to: Auto accident Work injury Other accident Illness Unknown cause

Date symptoms appeared _____ **If Accident, please describe what happened:** _____

What aggravates your condition: Standing Twisting Bending Sitting Lying Walking Coughing Lifting

What is your average pain rating over the past 2 weeks? (0-10) _____ (0= no pain, 10=max pain)

Are your symptoms:

- Improving (101)
- About the same (102)
- Getting Worse (103)
- Intermittent (come and go) (104)

List all surgical operations:

- (107)
- _____
- _____
- _____

List all non-prescription

- drugs you now take: (109)
- _____
- _____
- _____

Have you had these symptoms before?

- NO (105)
- YES When? _____

List all prescription drugs

- you now take: (108)
- _____
- _____
- _____

Check here if you have a history of

- diabetes (112)
- stroke
- cancer (113)
- cardiovascular disease (111)

Who is your family doctor? (106)
Dr. _____

Social Habits: (114) tobacco
Body Weight average

alcohol
 overweight

coffee
 obese

Have you had a history of chronic pain for more than 6 months? yes no

Do you currently suffer from depression or anxiety issues? yes no

Have you seen a chiropractor before? If so, when? _____

PLEASE CHECK ANY OF THE FOLLOWING THAT YOU MAY HAVE HAD: (118)

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Asthma | <input type="checkbox"/> Gastric Ulcers | <input type="checkbox"/> Joint Pains |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Colitis/Spastic Colon | <input type="checkbox"/> Jaw Pain |
| <input type="checkbox"/> Heart Murmurs | <input type="checkbox"/> Pulmonary Disease | <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Shoulder Pain |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Gas/Bloating | <input type="checkbox"/> Hepatitis A B C |
| <input type="checkbox"/> Sinus/Allergies | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Premenstrual Pains | <input type="checkbox"/> HIV+ / AIDS |

Who referred you to our office?

The above information is true and accurate to the best of my knowledge

Signature _____ Date _____