Rickert Chiropractic & Acupuncture, PC Electronic Health Records Intake Form

First Name:_____ **Last Name**:_____

Email address: _____@_____

Cell Phone #: _____ **Cell Phone Provider:** _____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

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

Race (Circle one): American Indian or Alaska Native / Asian / 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

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

Family Medical History *(Record <u>ONE</u> diagnosis in your family history and the affected*				
Diagnosis (Write in below)	Father	Mother	Sibling: (brother/sister)	Offspring: (son/daughter)
i.e. diabetes		*mother*		

Are you currently taking any medications? *(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

Have you had x-rays/MRI in the past 28 days? YES NO

Have you been diagnosed with high blood pressure? YES NO

Have you been diagnosed with Diabetes? YES NO

If yes, please list the date of last A1C and results: _____

□ **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:_____ /_____

NAME_____ ADMIT DATE _____ (MONTH DAY YEAR)

CONFIDENTIAL

PRESENT COMPLAINTS

PLEASE CHECK ALL ANSWERS AND FILL IN THE BLANKS WHERE APPROPRIATE. In the space below, please describe the present complaint(s) which brought you to this clinic for care. After completing this first section, please complete the questionnaire on the reverse side. The information you provide concerning past and present symptoms and diseases assists your doctor in obtaining an early understanding of your state of health.

PATIENT HEALTH QUESTIONNAIRE

1. Present Complaint:_____

2. Please describe the character of your current pain (YOU MAY CHECK ONE OR MORE ANSWERS): ☐ Sharp/Stabbing ☐ Sharp/Dull ☐ Aches ☐ Dull ☐ Soreness ☐ Weakness ☐ Throbbing/Gnawing ☐ Numbness ☐ Shooting ☐ Gripping/Constricting ☐ Burning ☐ Tingling

3. How often are the complaints present? ☐ Constant, (76–100%) ☐ Frequent (51–75%) ☐ Occasional (26–50%) ☐ Intermittent (25% or less).

4. How bad is your pain or ache? Please circle a number: 0 (NO PAIN) 1 2 3 4 5 6 7 8 9 10 (UNBEARABLE PAIN)

5. Since your problem began is the pain: ☐ Increasing ☐ Decreasing ☐ Not Changing

6. When did your problem begin: SPECIFIC DATE IF POSSIBLE? _____

7. Did your problem begin: ☐ Immediately after a specific incident ☐ Multiple incidents ☐ Gradually developed over time

8. Describe how your problem began: _____

9. What treatment have you received for this present condition? ☐ Surgery ☐ Spinal Injections ☐ Therapy from a PT ☐ A back support ☐ Other _____ If none check here ☐

10. Were you previously treated for a different occurrence of this same condition? ☐ Yes ☐ No. If yes by: ☐ Chiropractor ☐ MD ☐ Therapist ☐ Other _____ (SPECIFY DATES & TYPE OF TREATMENT WITH RESULTS) _____

11. What makes your problem better? ☐ Nothing ☐ Laying Down ☐ Walking ☐ Standing ☐ Sitting ☐ Movement/Exercise ☐ Inactivity ☐ Other _____

12. What makes your problem worse? ☐ Nothing ☐ Laying Down ☐ Walking ☐ Standing ☐ Sitting ☐ Movement/Exercise ☐ Inactivity ☐ Other _____

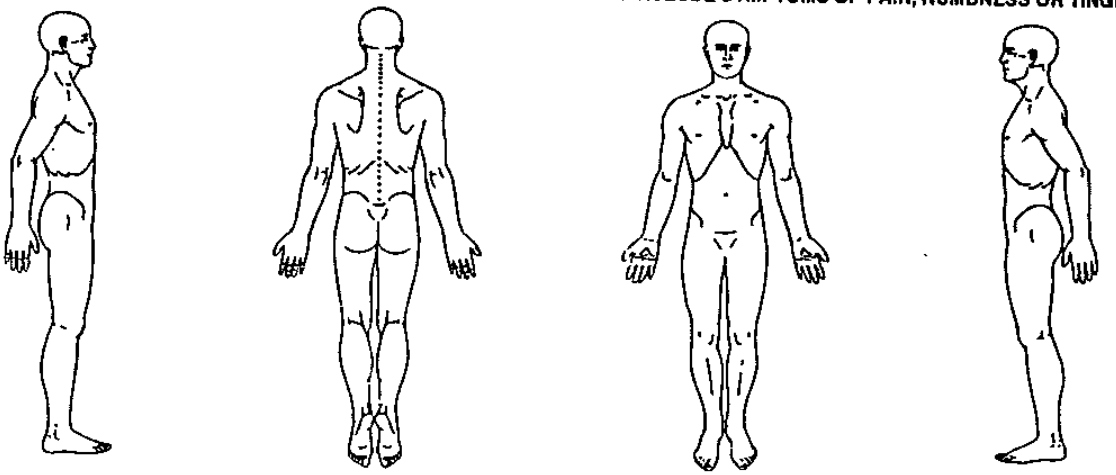
13. How would you grade your general stress level? ☐ No Stress ☐ Minimal Stress ☐ Moderate Stress ☐ Greatly Stressed

14. Physical activity at work: ☐ Sedentary More Than 50% of Workday ☐ Light Manual Labor ☐ Manual Labor ☐ Heavy Manual Labor

15. General physical activity: ☐ No Regular Exercise Program ☐ Light Exercise Program ☐ Strenuous Exercise Program

16. Are your complaints affecting your ability to work or otherwise be active?
- ☐ No effect
- ☐ Some physical restrictions (able to perform light duty work and houshold tasks).
- ☐ Need limited assistance with common everyday tasks.
- ☐ Need assistance often.
- ☐ Have a significant inability to function without assistance.
- ☐ Am totally disabled (impaired). Cannot care for self.

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS. INCLUDE SYMPTOMS OF PAIN, NUMBNESS OR TINGLING



Patient's Signature:_____ Date:_____

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