Patient Health History

Today's Date [/ /] **Signature of Patient**_____

Patient Title: *(check one)* ☐ **Mr.** ☐ **Mrs.** ☐ **Ms.** ☐ **Miss** ☐ **Dr.** ☐**Prof.** ☐**Rev.**

First Name_____ **Nick Name**_____

Last Name_____ **Middle Name**_____ **Suffix**_____

Address_____

City_____ **State**_____ **Zip Code**_____

Home Phone_____ **Mobile Phone**_____

Contact Method (check one)

☐Primary Phone ☐Mobile Phone ☐Email

Date of Birth [/ /] **Age**_____ **Gender** *(check one)* ☐ Male ☐Female ☐Unspecified

Marital Status *(check one)* ☐Single ☐Married ☐Other **SSN**_____

Name of Husband or Wife_____

Employment Status *(check one)*

☐Employed ☐FT Student ☐PT Student ☐Other ☐Retired ☐Self Employed

Employer's Name/ Occupation_____

Employer's Address/ Phone_____

Emergency Contact's Name/ Phone_____

For Insurance Purposes: Policyholder's Name/ DOB_____

Policyholder Address_____

Present Family Physician_____

May we send your doctor a letter regarding your treatment? ☐Yes ☐No **Initial**_____

How did you hear about us (circle one) *Newspaper / Website / Phone Book / Other Healthcare Provider /*

*Other*_____ */ Patient* _____

Konstant Chiropractic Clinic
1308 19th St. NE
Watertown, SD 57201

Electronic Health Records Intake Form

This form complies with CMS EHR incentive program requirements

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 in below)	Father	Mother	Sibling: (_____)	Offspring: (_____)

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

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

☐ **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:_____/_____