504 South Main Street ~ River Falls, WI 54022 ~ 715-426-4774
www.dchorizon.net

Electronic Health Records Intake Form

In compliance with Medicare requirements for the government EHR incentive program

Name (First, Last, & Middle Initial):___________________________________

Email Address:___________________________________ **DOB:**____________

Preferred method of communication for reminders *(circle one): Email / Phone / Mail*

Gender: *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 nature and frequency of chiropractic care.)

Patient Signature:___________________________________ **Date:**________________

Height:________ **Weight:**________ **Blood Pressure:** ___/___ ______