**Howell Chiropractic, Inc.**

Dr. Shawn M. Howell, D.C.

1311 East Stroop Rd. Kettering, OH 45429

Electronic Health Records Intake Form

(In compliance with requirements for the government EHR incentive program)

**First Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Last Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DOB:\_\_\_\_/\_\_\_\_/\_\_\_\_ Gender (circle one): Male / Female**

**Marital Status (circle one): Single / Married Preferred Language:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**Email address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Center for Medicare/Medicaid Services (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 Race

 I Decline to Answer

**Ethnicity (circle one):** Hispanic or Latino / NOT Hispanic or Latino / I Decline to Answer

Are you currently taking any medications?  **Yes or No.** If yes, please list below.

 (Please include regularly used over the counter medications/supplements/vitamins)

|  |  |
| --- | --- |
| **Medication Name** | **Vitamin and/or Supplement Name** |
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|  |  |
|  |  |
|  |  |

Do you have any medication allergies? **YES or NO.** If yes, please list allergy and reaction below.

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| --- | --- |
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⃝ 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.)

**Smoking Status** (circle one): Every Day / Occasional / Former / Never

If you are a smoker, would you like information on quitting smoking? **Yes / No**

**Diagnosed with Hypertension: Yes / No Diagnosed with Diabetes: Yes / No**

|  |
| --- |
| Office Use Only: **Height: \_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_\_ Blood Pressure: \_\_\_\_\_\_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |