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732 Main St Wabasso, MN (507) 342-2000
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Electronic Health Records Intake Form

In compliance with requirements for the government CMS program

❒Male ❒Female Pregnant? ❒No ❒ Yes, due date? ___/___/___ **Social Security #** ___ ___ ___/___ ___/___ ___ ___ ___

Last Name____________________________ **Legal First Name**____________________ **DOB:** ___/___/___

Preferred Name________________**Address:**____
(City) (State) (Zip Code)

Home Phone: (____)____-_______ **Cell phone:** (____)____-_______ **Work phone:** (____)____-_______

Email address:____

Occupation: _______________________________ **Employer Name**: ________________________________

Employer address: ____

Status: ❒ Single ❒ Married ❒ Divorced ❒ Widowed ❒ Legally Separated

Spouse Name: ______________ **# of Children**: ___ **Names**: ____

Will an insurance company be contributing to your care? ❒No ❒ Yes *(If no, ask us about our wellness plans)*

Primary: __________________________________ ***Secondary***: ___________________________________

Waiver: I authorize Fixen Chiropractic and my insurance company to process claims with my information. *(signature)*____ *(date)* ___/___/___

Waiver: I authorize my insurance company to release data and to contribute to my care at Fixen Chiropractic. *(signature)*____ *(date)*___/___/___

Waiver: I have been offered a copy of Fixen Chiropractic's *Notice of Privacy Practices*, and the following person(s) have permission to any and all of my records (if applicable).

____

*(signature)*____ *(date* ___/___/___

Waiver: I understand that there are minimal risks with Chiropractic Care, Acupuncture, and Physiotherapies.

*(signature)*____ *(date* ___/___/___

How were you referred to Fixen Chiropractic? *(Check One)*

❒Patient ______________________ ❒Internet ______________________ ❒Location
❒Physician ____________________ ❒Radio ❒Other __________________
❒Phone book ___________________ ❒Newspaper

Preferred Language: *(Fill in the Blank)* _____________________________

My race is: *(Check One)*

❒American Indian/Alaska Native ❒Black ❒White
❒Asian ❒Pacific Islander ❒Other __________________

My ethnicity is: *(Check One)*

❒ Hispanic or Latino ❒Not Hispanic or Latino

What is the major symptom/problem? ____

What were you doing when the condition started?_____________________________________

When did symptoms begin? ____

Have you had this problem before? ❒No ❒ Yes, when? ________________________________

Is the condition getting progressively worse? ❒No ❒ Yes

Pain scale: *(please circle)* *No pain* **1 2 3 4 5 6 7 8 9 10** *Severe pain*

When do you feel your pain more? *(Check One)*

❒ Morning ❒ Afternoon ❒ Evening ❒ Night

How often do you experience pain? (*Check One*)

❒None of the time ❒1-25% ❒26-50% ❒51-75% ❒76-99% ❒Constantly

Does it cause problems elsewhere? ❒No ❒ Yes Where**?** _________________________________

What makes the condition better? ____

What makes the condition worse? ____

What does it interfere with? *(Check all that apply)*

❒Sleep ❒Work ❒Housework ❒Routine ❒Recreation ❒Other_______________

Is it painful to perform any of the following? *(Check all that apply)*

❒Sitting ❒Bending ❒Reading
❒Standing ❒Lying down ❒Getting up
❒Walking ❒Driving ❒Other_______________

Have you had any traumas? *(check all that apply)*

❒Falls ❒Concussions ❒Broken bones
❒Head injuries ❒Auto Accidents ❒Other_______________
❒ER visits ❒Work Comp injuries

Please briefly describe: ____

Have you been seen by a chiropractor in the past? ❒No ❒ Yes **When?** _______________________

Who? ____

Are you currently taking medications, prescription drugs, and pain killers? ❒No ❒Yes

(Please include regularly used over the counter medications)

Prescription Name	Dosage	Frequency	What is it for?

Please provide past medical visit information. *Example: Cholesterol, Glucose, Thyroid, Mammogram etc.*

Name	Date	Result
	___/___/____	
	___/___/____	
	___/___/____	

Have you had any surgeries? ❒No ❒Yes *If yes, please list below*

Type of Surgery	Date	What was it for?	Any reaction?
	___/___/____		❒Yes ❒No
	___/___/____		❒Yes ❒No
	___/___/____		❒Yes ❒No

Please check all that apply to your health.

Ankylosing Spondilitis (M45.9) ❒	Tension Headaches (G44) ❒	IBS(K58) ❒/Crohn's (K50.90) ❒
Degenerative Disk Disease (M51, M50) ❒	Trigeminal Neuralgia (G50.0) ❒	Diverticulitis (K57.92) ❒
Facet Arthritis-Dorsopathy (M53) ❒	TMJ Disorder (M26.60) ❒	Diverticulosis(K57.90) ❒
Osteoarthritis-Extremity Joint-(M19) ❒	Vertigo (H81) /Dizziness(R42) ❒	Asthma (J45) ❒
Osteoporosis(M81.0)❒/Osteopenia ❒	Blood Pressure Issues ❒ High (I10) ❒Low (I95.0)	COPD (J44.9) ❒/ Emphysema (J43.9)❒
Psoriatic Arthritis (L40.9) ❒	Diabetes ❒ Type 1(E10.9) ❒Type 2 (E11.9) ❒Gestational (024.419)	Cystic Fibrosis (E84.9) ❒
Rheumatoid Arthritis (M06.9) ❒	Heart Attack (old-I25.2) ❒	Cerebral Palsy (G80.9) ❒
Scoliosis (M41) ❒	High Cholesterol (E78.5) ❒	Epilepsy (G40.9) ❒
Spondylolisthesis (M43) ❒	Thyroid Hypo(E03.9)❒/Hyper (E05.90) ❒	Multiple Sclerosis (G35) ❒
Spondylosis-Spine-DJD-(M47) ❒	Raynaud's Syndrome (I73.00) ❒	Parkinson's Disease (G20) ❒
Stenosis (M48.0) ❒	Poor circulation ❒	Stroke ❒/TIA❒
Arm Pain❒/Leg Pain ❒	Pace Maker ❒	Lupus ❒
Fibromyalgia (M79.7) ❒	Chronic Fatigue❒/Insomnia❒	Anxiety (F41.9) ❒/ Depression (F41.8) ❒
Sinus Infection ❒	Hepatitis ❒ A(B15.9) ❒ B(B19.10) ❒ C(B19.20)	Club Foot (Q66.89) ❒
Shingles (B02) ❒	Bladder Problems ❒	Gout (M1A/M1O) ❒
Headaches ❒	Kidney Stones ❒	Plantar Fasciitis(M72.2)❒/Foot Pain ❒
Cluster Headaches (G44) ❒	Irregular Cycle ❒	Other___________________ ❒
Migraines (G43) ❒	Celiac's (K90.0) ❒	

Cancer
❒ Liver (C22) ❒ Pancreatic (C25) ❒Skin (C43/C44) ❒Prostate (C61) ❒ Testicular (C62) ❒ Uterine (C55) ❒ Thyroid (C73)
❒ Brain (C71) ❒ Ovarian (C56) ❒ Throat (C15) ❒ Breast (C50) ❒Colon (C18) ❒ Lung (C34)
❒Other________________

Summary of your family history. *(Please check type and list whom)*

Cancer
❒Thyroid(C73)__________ ❒Liver(C22.9)___________ ❒Ovarian(C56.9)__________ ❒Prostate(C61)__________
❒Colon(C18.9)__________ ❒Lung(C34.90)___________ ❒Brain(C71.9)____________ ❒Skin(C43.9)__________
❒Testicular(C62.90)_______ ❒Uterus(C55)____________ ❒Pancreatic(C25.9)_________ ❒Throat(C15.9)____________
❒Breast(F-C50.919/M-C50.929)__________ ❒Other__________

Diabetes
❒Type 1(E10.9)____________ ❒Type 2(E11.9)________________

Heart Attack/Disease(I25.2) ❒__________________

Blood Pressure
❒High(I10)________________ ❒Low(I95.0)___________________

Scoliosis(M41.9) ❒_____________

Stenosis(M48.00) ❒_____________

Disc Disorder
❒Thoracic/Lumbar(M51.9)____________ ❒Cervical(M50.90)_______________

Please provide the date of last appointment for the following: **What part of the body?**

Medical Exam	Date: ___/___/____	_________________
Spinal X-Ray/Exam	Date: ___/___/____	_________________
MRI	Date: ___/___/____	_________________
CT-Scan	Date: ___/___/____	_________________

On a scale of 1 to 10, rate your stress level on a daily basis. *(Circle One)*

Least 1 2 3 4 5 6 7 8 9 10 *Most*

Smoking Status *(Check One)*

❒Every Day Smoker ❒Occasional Smoker ❒Former Smoker ❒Never Smoked

How many alcoholic drinks do you drink per week? *(Fill in the blank)*______________*per week*

How many caffeinated drinks do you drink per week? *(Fill in the blank)*______________*per week*

How do you perceive your weight? *(Check One)*

❒Obese ❒Normal weight ❒Underweight

❒Overweight ❒Slightly underweight

Are you interested in a *free* nutrition/weight loss consultation? ❒Yes ❒No

How do you think you eat? *(Check One)*

❒Not healthy ❒Somewhat healthy ❒Healthy

Have you ever been on a diet to lose weight? *(Check One)*❒Yes ❒No

If you answered yes above, have you ever had success with weight loss?❒Yes ❒No **If not, how come?**

❒Too hard ❒Family eating habits ❒No grocery store food choices

❒Not for me ❒Traveled

❒Too many habits to break ❒Eating healthy is too expensive

❒Social life got in the way

Are you currently taking supplements or vitamins? ❒No ❒Yes *If yes, please list below*

Supplement Name	Dosage	Frequency	What is it for?

Do you have any allergies? ❒No ❒Yes *If yes, please list below*

Allergy Name	Reaction	Onset date	Additional comments
		___/___/____	
		___/___/____	

Have you had any vaccinations and/or injections? ❒No ❒Yes *If yes, please list below*

Vaccine Name	Date	What was it for?	Any reaction?
	___/___/____		❒Yes ❒No
	___/___/____		❒Yes ❒No

Do you want a receipt of a clinical summary after every visit *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

❒ No, I **<u>do not</u>** want a summary receipt after every visit.

❒ Yes, I want a summary receipt even though it may be blank.

Patient Signature: ____ Date___/___/___

Office Use Only	*HT:*	*WT:*	*lbs*	*BP:*	*/*	*O2:*	*Pulse:*