Aldana Chiropractic
Electronic Health Records Intake Form

Name (please print)____

Email ____________________________________ Phone number ________________

Preferred Language: ☐ English ☐ Japanese ☐ Spanish ☐ Other ________________

Center for Medicare Services requires providers to anonymously report both race and ethnicity.

Ethnicity (check one) ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ I Decline to Answer

Race (check one) ☐ White (Caucasian) ☐ Asian ☐ American Indian or Alaska Native

☐ Black or African American ☐ Pacific Islander ☐ I Decline to Answer

Smoking Status (check one) ☐ Never Smoked ☐ Current Everyday ☐ Current Somedays

☐ Light Smoker ☐ Former Smoker (no longer smoke)

Are you currently taking any medications? ☐ YES ☐ NO

(Prescription and Non-Prescription) Please do not include supplements/vitamins.

Medication Name	Dosage & Frequency (i.e. 5mg once a day, etc)

Do you have any medication allergies? ☐ YES ☐ NO

Medication Name	Reaction (i.e. Hives, Rash, Vomit)	Estimated year reaction discovered

☐ I prefer to receive a receipt of my clinical summary after every visit. (Digital copy will be sent if email is on file)

Clinical Summary = After-visit summary containing patient name, reason for visit, office contact information.

____ ______________________

Signature Date

FOR OFFICE USE ONLY

Height:______ Weight:______ lbs Blood Pressure______/______ Pulse ______ bpm Sp02______