PIKE CHIROPRACTIC INC
35 POPLAR STREET
DANVERS,MA 01923

Electronic Health Records Intake Form

In compliance with requirements for the government EHR program

First Name:_____ **Last Name:**_____

Email address: _____@_____

Preferred method of communication for 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

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, use back of page if needed)

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 do ☐ **I do not want a copy of my clinical summary after every visit** (Clinical summaries do not include chart notes. It includes insurance coding and the list of medications that you are providing on this form)

Patient Signature: _____ Date:_____

Height: _____ Weight:_____ Blood Pressure:_____ /_____