Yakima Valley Chiropractic Center, PS
W. Duane Harrington, DC
1120 S 4th St
Sunnyside, WA 98944

Electronic Health Records Intake Form

This form complies with CMS EHR incentive program requirements

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

Email address: _____@_____

Preferred method of communication for patient 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

Smoking Start Date (Optional): _____

Family Medical History ***(Record one diagnosis in your family history and the affected***				
Diagnosis (Write in below)	Father	Mother	Sibling: (_____)	Offspring: (_____)
Example: Heart Disease		*X*		

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? *(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 the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date: _____

For office use only

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

PATIENT INFORMATION

Name _____ Date_____
(First) (Middle) (Last) Marital Status_____
Mailing Address_____
Home Address (if different than mailing address)_____
City _____ State____ Zip code_____
Home Phone _____ Cell Phone_____ Work phone_____
Email address_____
Date of Birth _____ Soc Sec # _____ Medicare # _____

Employer _____ Phone # _____

Spouse's Name_____ Date of birth_____ Soc Sec # _____
Spouse's Employer _____ Phone #_____

If Minor, Father's name_____ Employed By _____
Soc Sec # _____ Date of Birth _____

Mother's Name _____ Employed By_____
Soc Sec # _____ Date of Birth_____

In an Emergency Contact _____ Phone # _____

INSURANCE INFORMATION

Name of Insurance _____

Subscriber's Name _____ Group # _____ID # _____
Was this an on-the- job injury? Yes ___ No____ If yes Date of Injury _____
Was this a Motor vehicle accident Yes___ No___ If yes Date of Injury

PLEASE ADVISE US IF YOU HAVE AFLAC

Who is Responsible for this account _____
(Women) are you pregnant? Yes ____ No ___
Referred By _____

Signature_____

YAKIMA VALLEY CHIROPRACTIC CENTER, P.S.
DR. W. DUANE HARRINGTON D.C.
509-837-2600

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HEALTH HISTORY

Patient Name _____ Date _____

Purpose of this appointment/major complaint? _____

What activities aggravate your condition? _____

Is this condition getting progressively worse? Yes ___ No ___ Constant ____ Comes/Goes ____

Is this condition interfering with your: work ____ sleep____ Daily routine ____

How long has it been since you really felt good? _____

What do you believe is wrong with you? _____

Have you seen any other doctors for this condition? Date _____ Dr. Name _____

Address _____ Phone # _____

Have you been treated for any health conditions by a physician in the last year? _____

Describe _____

What medication or drugs are you now taking? _____

_____

Is this condition due to injury or sickness arising out of patient's employment? _____

Date symptoms appeared or accident happened? _____

Patient ever had same or similar condition? Yes _____ No _____

If Yes, when and describe _____

Have you lost any days from work/school? _____

Date of last physical examination? _____

What operations have you had? _____

Serious illness? _____

Are you pregnant? (Women) Yes _____ No _____

HAVE YOU EVER SUFFERED FROM:

____Dizziness
____Fatigue
____Headaches
____Loss of Sleep
____Ulcers
____Numbness
____Bursitis
____Foot trouble
____Low back pain
____Neck pain or stiffness
____Poor posture
____Sciatica
____Swollen joints
____Stroke
____Chest pain

____Hemorrhoids
____Nausea
____Colds
____Deafness
____Ear noises
____Eye Pain
____Failing vision
____Venereal Disease
____Tuberculosis
____Hay fever
____Nosebleeds
____Sinus infection
____Pain over heart
____Anemia
____Difficult digestion

____Pleurisy
____Spitting
____Itching
____Varicose Veins
____Bed Wetting
____Frequent urination
____ Prostate trouble
____ Cramps/backache
____ Hot Flashes
____Irregular cycles
____Alcoholism
____Spinal curvatures
____Colon trouble
____Diarrhea
____Difficult breathing

TINGLING OR NUMBNESS IN:

____Shoulders ____Legs ____Arms
____Knees ____Elbows ____Feet
____Hands ____Hips

HAVE YOU OR ANY OF YOUR IMMEDIATE FAMILY SUFFERED FROM:

____Arthritis ____Asthma ____Enlarged thyroid
____Bruise easily ____Poor circulation ____Rapid heart beat
____Slow heart beat ____Nervousness/depression ____Cancer Type? _____
____Kidney stones ____Lumps in breast ____Diabetes
____High blood pressure ____Low blood pressure
____Allergies (to what?) _____

PERSONAL HABITS:

	HEAVY	MODERATE	LIGHT	NONE
Alcohol	_____	_____	_____	_____
Coffee	_____	_____	_____	_____
Tobacco	_____	_____	_____	_____
Drugs	_____	_____	_____	_____
Exercise	_____	_____	_____	_____
Sleep	_____	_____	_____	_____
Appetite	_____	_____	_____	_____

PAYMENT IS EXPECTED AT TIME OF VISIT – (PLEASE READ)

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Yakima Valley chiropractic Center will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to the Yakima Valley Chiropractic Center will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I have read and understand the above and accept the terms and conditions.

SIGNATURE _____ **DATE** _____

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