Bend Chiropractic Clinic, P.C.

EHR History & Examination

Patient Name_____ Date _____

***Ethnicity (circle one)*:** Non-Hispanic or Latino Hispanic Decline/Prefer not to say

***Preferred language (circle one)*:** English Spanish Other_____ Decline/Prefer not to say

***Race (circle one)*:** White/Caucasian Black/African American Indian or Alaska Native Asian
Native Hawaii or Pacific Islander Other_____ Decline/Prefer not to say

1. I prefer and give my consent to have my personal health information communicated by:
(PLEASE INITIAL CHOICE AND LIST ADDRESS OR PHONE NUMBER)

_____ Mail:_____

_____ Home Phone:_____ ☐ Talk ☐ Text ☐ Leave Message

_____ Cell Phone:_____ ☐ Talk ☐ Text ☐ Leave Message

_____ No preference

2. Are you taking any medications? ☐ YES ☐ NO

Medication Name	Dosage and frequency (i.e. 5mg once a day)

3. Are you allergic to any Medications? ☐ YES ☐ NO

Medication Name	Reaction	Onset date

Family History	Specify Type	Mother	Father	sister	brother	son	daughter
Arthritis							
Cancer							
Diabetes							
Heart Disease							
Hypertension							
Stroke							
Thyroid							
Other							

☐ ***Current Smoker*** ☐ ***Someday Smoker*** ☐ ***Everyday Smoker*** ***Former smoker*** ☐ ***Never smoked***

Have you tried to quit? ☐ YES ☐ NO What methods did you use _____

DOCTOR ONLY

Height_____ Weight_____ BP_____ Pulse _____

Grip R _____L_____ TLC _____ _____ _____ Pregnant ☐ YES ☐ NO