

WOODLAKE CHIROPRACTIC  
6701 Lyndale Avenue South  
Richfield, MN 55423  
Phone: 612-866-9194 Fax: 612-866-9963

## Electronic Health Records Intake Form

*In compliance with Medicare requirements for the government EHR incentive program*

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Email Address: \_\_\_\_\_

Preferred Phone #: \_\_\_\_\_ Is it okay to leave a detailed message? Yes / No

Preferred method of communication for patient reminders (circle one): Email / Phone / Mail

DOB: \_\_\_\_\_ Gender: Male Female

Preferred Language: English or \_\_\_\_\_

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  
Native Hawaiian or Pacific Islander White/Caucasian 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)

MEDICATION NAME	DOSAGE AND FREQUENCY (i.e., mg once a day)

Do you have any medication allergies?

MEDICATION NAME	REACTION	ONSET DATE	ADDITIONAL COMMENTS

Do you have high blood pressure? Yes / No

Do you have diabetes? Yes / No

I choose to receive clinical summaries of my office visits only upon my request.  
(Summaries are often blank as the result of the nature and frequency of chiropractic care.)

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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