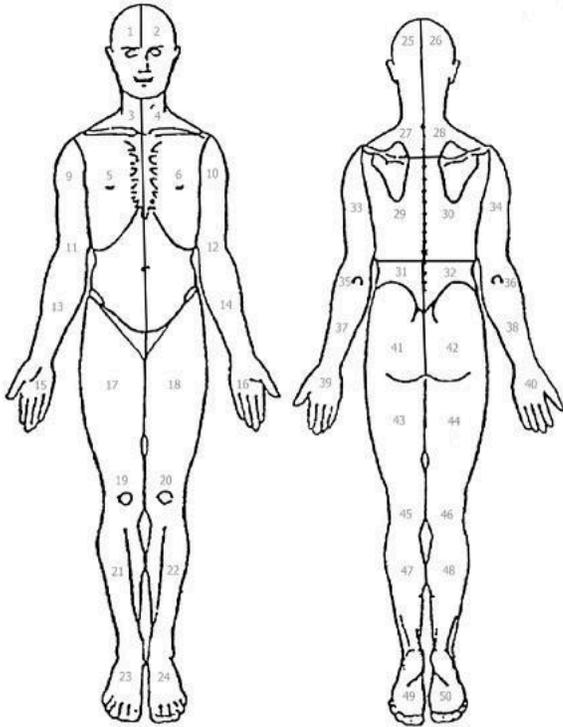


**PLEASE MARK AN "X" ON THE DIAGRAM BELOW WHERE YOUR PROBLEMS ARE LOCATED**



**WHAT HURTS? HOW LONG HAS IT HURT?**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

**WHEN DO YOU THINK THESE PROBLEMS ORIGINALLY STARTED?**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

**LIST OTHER CHIROPRACTORS OR MEDICAL DOCTORS YOU HAVE CONSULTED FOR THESE CONDITIONS.**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

**DO YOU HAVE ANY OTHER INJURIES, ILLNESSES, CONDITIONS OR HEALTH CONCERNS?**

**CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE LAST SIX (6) MONTHS:**

- |   |   |
|---|---|
| <input type="checkbox"/> HEADACHES                    | <input type="checkbox"/> NUMBNESS                     |
| <input type="checkbox"/> SINUS CONGESTION/ALLERGIES   | <input type="checkbox"/> FREQUENT NAUSEA/VOMITING     |
| <input type="checkbox"/> VISION PROBLEMS              | <input type="checkbox"/> ABDOMINAL CRAMPS             |
| <input type="checkbox"/> EAR ACHES                    | <input type="checkbox"/> CONSTIPATION                 |
| <input type="checkbox"/> DIZZINESS                    | <input type="checkbox"/> DIARRHEA                     |
| <input type="checkbox"/> HEART PROBLEMS               | <input type="checkbox"/> POOR/EXCESSIVE APPETITE      |
| <input type="checkbox"/> LUNG PROBLEMS                | <input type="checkbox"/> ABDOMINAL CRAMPS             |
| <input type="checkbox"/> BLOOD PRESSURE PROBLEMS      | <input type="checkbox"/> PAINFULS/EXCESSIVE URINATION |
| <input type="checkbox"/> ANKLE SWELLING               | <input type="checkbox"/> DISCOLORED URINE             |
| <input type="checkbox"/> PROSTATES/SEXUAL DYSFUNCTION | <input type="checkbox"/> DIABETES                     |
| <input type="checkbox"/> MENSTRAL CYCLE DYSFUNCTION   | <input type="checkbox"/> CANCER                       |

**ARE YOU PREGNANT**  Yes  NO **If yes how many weeks?** \_\_\_\_\_ **Due Date** \_\_\_\_\_

**DO YOU PLAN ON BECOMING PREGNANT IN THE NEAR FUTURE?**  YES  NO

**DO YOU HAVE ANY PREGNANCY CONCERNS, DISCOMFORTS PAINS OR ANY OTHER ISSUES YOU'D LIKE TO DISCUSS**

## Confidential Patient information

Name \_\_\_\_\_ Gender \_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
Name you prefer to be called \_\_\_\_\_  
Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
SSN \_\_\_\_ - \_\_\_\_ - \_\_\_\_\_ Marital Status M \_\_\_\_ S \_\_\_\_ D \_\_\_\_ W \_\_\_\_ Spouse/Partners Name \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Email \_\_\_\_\_ No. of Children \_\_\_\_\_ Ages \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
Have you previously had any Chiropractic Care? Y \_\_\_\_ N \_\_\_\_ If yes, When? \_\_\_\_\_  
Whom may we contact for referring you to us? \_\_\_\_\_

---

**All payments are due when the services are rendered.**

**Please choose from the following payment options:**

\_\_\_ **MEDICARE** You are responsible for charges at time of service, we will submit the charges to Medicare for you. If any reimbursement is approved by Medicare and/or any secondary policy, this will be sent directly to you! If you have not received anything within 6-8 weeks, please let us know

\_\_\_ **SELF PAY** We Offer several convenient methods of payment: Credit Card, Cash or Check. You are responsible for charges at the time of service. We will provide you with a fee slip which you may submit to your insurance for reimbursement directly to you!

\_\_\_ **PERSONAL INJURY** If your injuries were caused by an auto or work accident, please complete our Personal Injury Form. We will provide treatment at no out of pocket cost to you, provided you have med pay on your auto policy and pre-authorization from workman's compensation.

**If this accident related, (Personal, work, or auto related) please inform the front desk as soon as possible**

---

### **NO SHOW POLICY**

**Existing Patients:** We allow a 1 time "no show" occurs again a \$25 dollar fee will be charged to card on file.

**New Patients:** If you "no show" your originally scheduled appointment but would like to reschedule an appointment an additional \$25 charge will be applied to your first visit. If it occurs again a \$25 dollar fee will be charged to the card on file.

**Credit Card Number** \_\_\_\_\_ **Expiration Date:** \_\_\_\_\_ **CVV Code** \_\_\_\_\_

**CANCELLATION POLICY:** If you cannot, make your appointment we ask you cancel/reschedule 30 mins prior to your scheduled appointment time

**I HAVE READ AND UNDERSTAND THE TERMS OF THESE NEW CONDITIONS**

I authorize Lancasters Family and Pediatric Chiropractic to render necessary services to me and I am responsible for all charges incurred at the time of treatment.

**Patient/Guardian Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

I also acknowledge that the staff of Lancaster Chiropractic will occasionally give your child love i.e.: hugs and kisses.

**Patient/Parent initial if applicable** \_\_\_\_\_ **Date** \_\_\_\_\_