CONFIDENTIAL PATIENT INFORMATION

Name__________________________________ Gender_______ Date of Birth_____________ Age ________

Home Phone (____) _____________ Work Phone (____) ______________ Cell Phone (____) ____________

Please circle your preferred number to be contacted!

Address____________________________________City___________________State______Zip____________

SSN ____-____-____ Marital Status: ☐ M ☐ S ☐ D ☐ W Spouse/Partner Name___________________

Occupation___________________________________ Employer______________________________________

Email__________________________________ No. of Children_______ Ages____________________________

Emergency Contact________________________ Relationship______________ Phone (___) _____________

Have you previously had Chiropractic Care? ☐ Yes ☐ No If yes, when? _____________________________

Whom may we thank for referring you to us? ____

Is this injury or illness accident related? ☐ Yes ☐ No ***If yes, please complete PI form***

★★★

All payments are due when 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, and you will receive reimbursement from Medicare and any secondary policy directly to you!

☐ HEALTH INSURANCE you are responsible for charges at time of service. We will provide you a fee slip which you may submit for reimbursement directly to you!

☐ SELF PAY we offer several convenient methods of payment, Credit Card, cash, or check.

☐ CARE CREDIT FINANCING same as cash and low interest options are available in 6 to 24 month intervals. Ask an assistant for an application and brochure today!

☐ 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, or pre-authorization from workman's compensation.

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WHY CHIROPRACTIC? People go to chiropractors for a variety of reasons. Some go for the symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Your Chiropractor will weigh your needs and desires when recommending your treatment program.

RELIEF CARE	CORRECTIVE CARE
Relief care is that care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.	Corrective care differs from relief care in that its goal is to get rid of the symptoms or pain by correcting the CAUSE of the problem. Corrective care varies in length of time, but is more lasting.

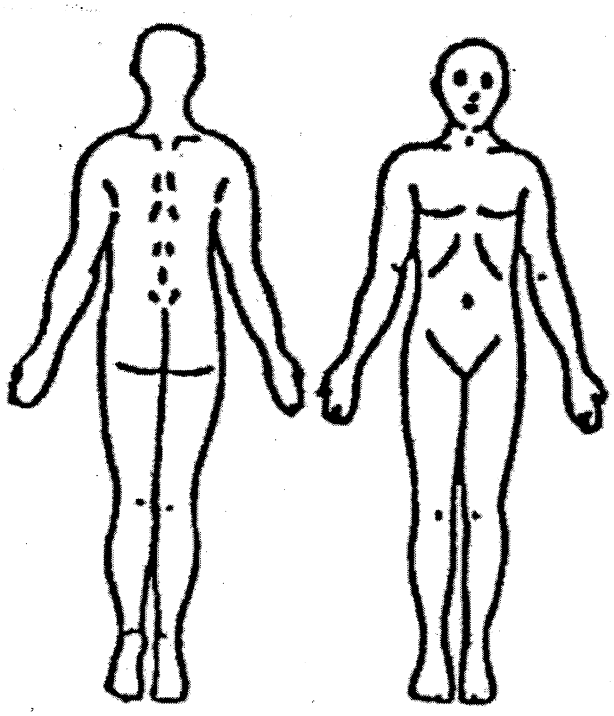
I authorize Lancaster Family & Pediatric Chiropractic to render necessary services to me and I am responsible for all charges incurred at the time of treatment.

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: __________________

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. _____

ARE YOU PREGNANT? ☐ Yes ☐ No **IF YES, HOW MANY WEEKS?** _____ **DUE DATE:** _____

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

_____

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

- ☐ HEADACHES
- ☐ SINUS CONGESTION/ALLERGIES
- ☐ VISION PROBLEMS
- ☐ EAR ACHES
- ☐ DIZZINESS
- ☐ HEART PROBLEMS
- ☐ LUNG PROBLEMS/CONGESTION
- ☐ BLOOD PRESSURE PROBLEMS
- ☐ ANKLE SWELLING
- ☐ PROSTATE/SEXUAL DYSFUNCTION
- ☐ MENSTRUAL CYCLE DYSFUNCTION
- ☐ NUMBNESS
- ☐ FREQUENT NAUSEA/VOMITING
- ☐ ABDOMINAL CRAMPS
- ☐ CONSTIPATION
- ☐ DIARRHEA
- ☐ POOR/EXCESSIVE APPETITE
- ☐ EXCESSIVE THIRST
- ☐ PAINFUL/EXCESSIVE URINATION
- ☐ DISCOLORED URINE
- ☐ DIABETES
- ☐ CANCER

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

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