FAMILY CHIROPRACTIC OF LANCASTER COUNTY, LTD
1717 OLD PHILADELPHIA PIKE, LANCASTER, PA 17602
PHONE: (717) 393-9955 FAX: (717) 393-6001

Date: _____
Acct #: _____

PATIENT INFORMATION (Please Print)

Name: _____ Social Security #: ___-___-____
(Last) (First) (Middle)

Mailing Address: _____
(City/State) (Zip)

Cell #: _____ Carrier: _____ Home #: _____ Work #: _____ Ext: _____

Email Address: _____ Sex (Circle One): Male Female
Do you prefer a text or email reminder for any appointments? Text Email

Employer: _____ Occupation: _____ ☐ FT ☐ PT

Employer Address: _____
(City/State) (Zip)

Birth Date: _____ Age: _____ Marital Status (Circle One): Single Married Widowed Divorced

Spouse's Name: _____ Parent/Guardian (If patient under 18): _____

Who may we thank for referring you? _____

Emergency Contact: _____ Phone: _____
(Name) (Relationship)

Is your visit due to: ____ Auto Accident ___ Work injury ___ Other Party Liability ___ Home Accident ___ Unknown

Insurance Information:

Insurance Company: _____ Effective Date: _____

ID or Contract #: _____ Group #: _____

Phone #: _____ Are you the Policyholder? (Circle One) Yes No

If you are not the Policyholder provide the following information:

Name of Policyholder: _____ Relationship: _____

Policyholder Birthdate: _____ Policyholder Telephone Number: (_____) _____

Policyholder's Address: _____
(City/State) (Zip)

Policyholder's Employer: _____ Occupation: _____

Release of Information/Insurance Payment Authorization/Medical Records Release

This authorization, or photocopy hereof, will authorize Family Chiropractic of Lancaster County to furnish all information they may have regarding my condition while under care, including the history obtained, X-Ray and physical findings, diagnosis and prognosis, to the responsible insurance carrier or other health care provider. Necessary information may be given to my employer concerning my condition. I also assign insurance benefits to Family Chiropractic of Lancaster County. I permit this office to endorse remittance for the conveyance of credit to my account. HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT.

Patient/Guardian Signature: _____ **Date:** _____

Consent for Treatment

I authorize the doctors of Family Chiropractic of Lancaster County and whoever they may designate as their assistant(s) to examine, perform diagnostic tests, including but not limited to radiographs, and to administer treatment as necessary. I understand that the doctors of Family Chiropractic of Lancaster County will do their best to obtain a positive result for my condition however I certify that no guarantee or assurance is implied or made as to the results that may be obtained from treatment. If the patient is a minor, as parent/guardian, I give consent for treatment to be administered.

Patient/Guardian Signature _____ **Date:** _____

PLEASE PRESENT YOUR INSURANCE CARDS AND DRIVERS LICENSE TO THE FRONT DESK

DATE OF ROF: _____

DATE OF NEXT APPOINTMENT: _____

PATIENT PHONE NUMBER (FOR VERIFICATION) _____

OTHER: _____

CHIROPRACTORS YOU HAVE SEEN IN THE PAST

NAME _____ DATE OF LAST VISIT _____
NAME _____ DATE OF LAST VISIT _____

MEDICAL DOCTORS CONSULTED WITHIN THE PAST YEAR

NAME _____ CONDITION _____
NAME _____ CONDITION _____

REASON FOR TODAY'S APPOINTMENT IN ORDER OF SEVERITY:	DATE STARTED OR FOR HOW LONG?	HAVE YOU HAD THIS BEFORE?	INJURY RELATED?
1. _____	_____	YES NO	YES NO
2. _____	_____	YES NO	YES NO
3. _____	_____	YES NO	YES NO
4. _____	_____	YES NO	YES NO

PREVIOUS SURGERIES (PLEASE LIST ALL TYPES) :

1. TYPE _____ DATE _____
2. TYPE _____ DATE _____
3. TYPE _____ DATE _____

DO YOU HAVE A "DO NOT RESUSCITATE ORDER" OR LIVING WILL? YES / NO

PREVIOUS ACCIDENTS OR INJURIES (ESPECIALLY THOSE THAT RELATE TO YOUR PRESENT PROBLEMS)

1. TYPE _____ DATE _____
2. TYPE _____ DATE _____
3. TYPE _____ DATE _____
4. TYPE _____ DATE _____
5. TYPE _____ DATE _____

MEDICATIONS (PRESCRIPTIONS, VITAMINS, OTHER) _____

_____

PLEASE CIRCLE THE FOLLOWING CONDITIONS YOU MAY HAVE HAD OR HAVE NOW

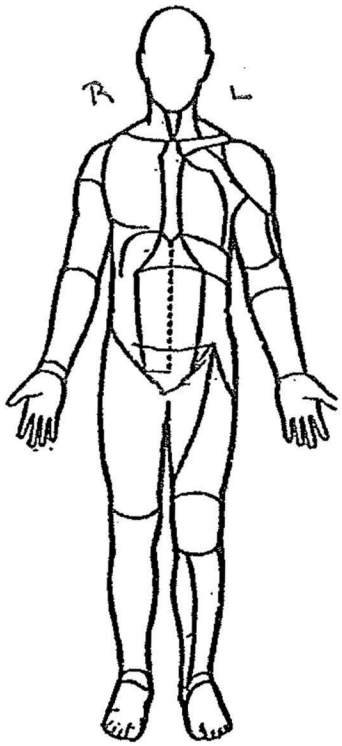
ALLERGY	DIARRHEA	EPILEPSY	HEADACHES
ALCOHOLISM	ECZEMA	MEASLES	STROKE
ANEMIA	GALL BLADDER	MISCARRIAGE	ULCERS
ARTHRITIS	HEART ATTACK	MULTIPLE SCLEROSIS	HIGH BLOOD PRESSURE
JAW PAIN	NECK PAIN	VENEREAL DISEASE	BACK PAIN
CANCER	HEART DISEASE	NEURITIS	AIDS
CONVULSIONS	MUMPS	NERVOUSNESS	PLEURISY
COLD SORES	LOW BLOOD SUGAR	DEPRESSION	BLOOD VESSEL DISEASE
CONSTIPATION	MENSTRUAL CRAMPS	TUBERCULOSIS	PREGNANT LMP ___/___/___
DIABETES	IRREGULAR PERIODS	PNEUMONIA	GOUT

PATIENT NAME: _____
ACCOUNT NUMBER: _____
DATE: _____

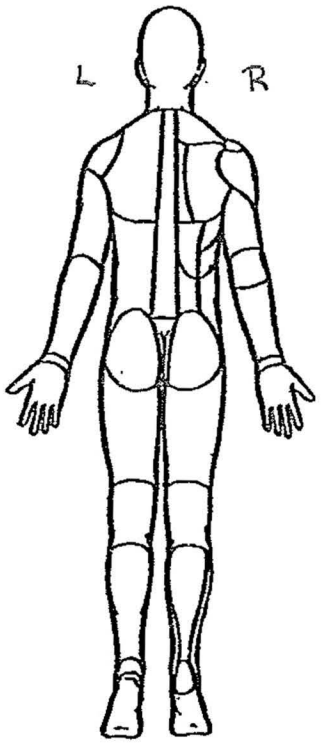
Indicate below any numbness, tingling, burning, stiffness, aches, pain or other symptoms you may have in the diagram below. Please shade in the area of difficulty you are having and mark that area with the following key to indicate type.

Numbness	= N
Tingling	= T
Burning	= B
Stiffness	= S
Dull Ache	= D
Sharp Pain	= P

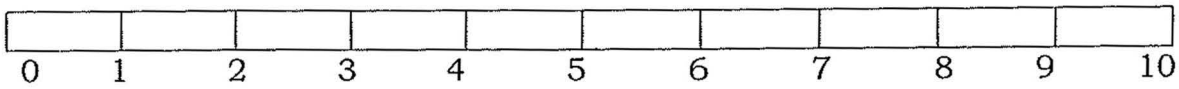
Front



Back



3. Indicate intensity of pain on a scale of (0 is no pain and 10 means you need to go to the hospital)



 # 0 No pain
 # 1 Pain is "a little uncomfortable" and the symptom does not recur more than once a week.
 # 2 Pain is "a little uncomfortable", except days can go by without being aware of it.
 # 3 The pain is a little more than a nuisance, and the pain may be absent for a whole day at a time.
 # 4 The pain is a little more than a nuisance, and you go through the whole day aware, but never affected by it.
 # 5 The pain is moderate but too frequent to ignore, no activities are affected.
 # 6 The pain is moderate but too frequent to ignore, some activities are affected. Hours go by without pain.
 # 7 The pain is significant, but not constant. Most activities are affected; you think about it once or twice an hour.
 # 8 The pain is significant, but not constant. Most activities are affected; your pain is moderately intense at times.
 # 9 Your pain is intense, constant, greatly restricts your activities, but you can forget about the pain up to15 minutes.
 # 10 Your pain is intense, constant, greatly restricts your activities, it is impossible to go more than 5 minutes without pain. (Pain is so great you have considered going to the hospital.)

PATIENT NAME: _____

ACCOUNT NUMBER: _____

DATE: _____