# LANCASTER CHIROPRACTIC PC

## NEW PATIENT INFORMATION FORM (Page 1 of 2)

Name _____ Date _____

Address _____ Apt. #_____

City _____ State_____ ZIP_____

Phone _____ Cell _____ Work Phone _____

Date of Birth _____ Age _____ Sex: M / F Height _____ Weight _____

SS# _____ Do you have Medicare? Yes / No ☐

Email Address: _____

Occupation _____ Employer_____

Current Working? Yes / No Who referred you here?_____

Emergency Contact _____ Phone_____

May we leave home or cell messages/voicemails/texts on your phone containing information about your appointment times and health information? Yes / No ☐

What are your symptoms / pains and when did they start?_____

_____

Medications/drugs being taken: _____

Family physician? _____ Phone number? _____

List any nutritional supplements you take: _____

Do you take COUMADIN or other blood thinners? Y / N ☐ Are you pregnant? Y / N ☐

List any major illnesses: _____

_____

List any surgeries or operations you have had: _____

_____

Has your Gallbladder been removed? Y / N

Past accidents or injuries: _____

_____

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## NEW PATIENT INFORMATION FORM (Page 2 of 2)

Name: _____

Marital Status: S M D W ☐ Name of Spouse _____

Number of children if any: _____

Any family history of serious illnesses: Cancer / Diabetes / Heart / Other _____

Do you have any HEART CONDITIONS? Y / N ☐

Have you been restricted from EXERCISING by a doctor? Y / N ☐

How did you hear about Lancaster Chiropractic PC ? _____

**PLEASE CHECK THE CONDITIONS YOU HAVE OR HAVE HAD IN THE PAST:**

| | | | |
|---|---|---|---|
| ☐ Alcoholism | ☐ Anemia | ☐ Anorexia | ☐ Allergies |
| ☐ Appendicitis | ☐ arthritis | ☐ asthma | ☐ Blood Disorders |
| ☐ blood in stool | ☐ vomiting | ☐ "heart burn" | ☐ cold sores |
| ☐ blood in urine | ☐ urine problems | ☐ bowel problems | ☐ nausea |
| ☐ bone aches | ☐ joint aches | ☐ depression | ☐ High or low blood pressure |
| ☐ Breast Lump | ☐ Bronchitis | ☐ Cancer | ☐ Cataracts |
| ☐ bruise easily | ☐ dizziness | ☐ head ache | ☐ loss of weight |
| ☐ chicken pox | ☐ Diabetes | ☐ emphysema | ☐ epilepsy |
| ☐ fractures | ☐ glaucoma | ☐ goiter | ☐ gonorrhea |
| ☐ gout | ☐ heart disease | ☐ hepatitis | ☐ hernia |
| ☐ heart attack | ☐ feel cold | ☐ anxiety | ☐ Drug dependency |
| ☐ herniated disc | ☐ high cholesterol | ☐ HIV / aids | ☐ kidney disease |
| ☐ itching | ☐ change in moles | ☐ rashes | ☐ knee pain |
| ☐ liver disease | ☐ measles | ☐ migraines | ☐ miscarriage |
| ☐ monucleosis | ☐ mult. Sclerosis | ☐ mumps | ☐ osteoporosis |
| ☐ numb arm/hand | ☐ poor circulation | ☐ ringing in ears | ☐ sweats |
| ☐ numb leg/foot | ☐ weakness | ☐ ankle pain | ☐ feel hot |
| ☐ pacemaker | ☐ Parkinson's | ☐ pinched nerve | ☐ pneumonia |
| ☐ polio | ☐ prostate | ☐ prosthesis | ☐ psychiatric care |
| ☐ Rheumatoid | ☐ rheumatic fever | ☐ scarlet fever | ☐ stroke |
| ☐ stiffness | ☐ cramps | ☐ muscle spasms | ☐ muscle aches |
| ☐ suicide attempt | ☐ thyroid problem | ☐ tonsillitis | ☐ tumors/growths |
| ☐ swollen ankles | ☐ blurred vision | ☐ cough | ☐ mouth sores |
| ☐ typhoid fever | ☐ ulcers | ☐ STD | ☐ venereal diseases |

ASSIGNMENT AND RELEASE I, the undersigned, authorize Dr. Michael Weig to administer treatment, as he deems necessary to myself. I assign directly to Michael Weig D.C. all medical benefits, if any, otherwise payable to me for services rendered. I hereby authorize the doctor to release all information necessary to secure the payments of benefits and authorize the release of any medical records to him. I authorize the use of this signature on all my medically related submissions. I certify that the above health information, that I provided, is true and correct to the best of my knowledge.

SIGNED: _____ DATE _____