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 ______________