



1873 Lincoln Highway East
Lancaster, PA 17602
T:(717)690-2169
F:(717)690-2163

Date:____/____/____

Patient Title: (check one) Mr. Mrs. Ms. Miss Dr. Prof. Rev.

First Name_____ Last Name _____

Middle Name_____Suffix_____ Date of Birth: ____/____/____ Age _____

Sex assigned at birth (check one) Male Female

Gender ID (check one) Male Female Transgender _____

Address 1 _____

City_____ State_____ Zip Code _____

Home Phone _____ Work Phone _____

Mobile Phone _____ Best one to reach you at? (check one) Mobile Home Work

Home Email _____ Work Email _____

Which email address would you like receive appointment reminders to (3 days before appointment)? Home Work

Would you like text message reminders (2 hours before appointments) to be sent to your mobile phone? Yes No

- **Marital Status** (check one) Single Married Divorced Partnership Widow/Widower
- **Race** (check one) White Black/African American American Indian/Alaskan Native Hispanic Asian
 Native Hawaiian or other Pacific Island Other _____ I choose not to specify

• **Employment Status** (check one)

Employed Self Employed Unemployed Retired Student SAHM/Homemaker Other

Employer Name _____ Phone Number _____

Job Description _____

Please list current medications (prescription, over-the-counter and supplements) including frequency and dosage if known.

If there are no current medications, check here:

- 1) _____ 5) _____
- 2) _____ 6) _____
- 3) _____ 7) _____
- 4) _____ 8) _____

List any known allergies you have had to any medications.

If no allergies are known, check here:

- 1) _____ 3) _____
- 2) _____ 4) _____

Review of Health History/Body Systems

Please check any and all that apply to you currently or in the past.

- | | | |
|--|---|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Stroke | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Heart Attack/MI | <input type="checkbox"/> Hair Loss |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Thyroid Issues |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Apnea | <input type="checkbox"/> Immune disorders |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Low Energy |
| <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Shortness Breath | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Diabetes: |
| <input type="checkbox"/> Foot/Ankle Pain | | Type 1 |
| <input type="checkbox"/> Shoulder Pain | | Type 2 |
| <input type="checkbox"/> Elbow/Wrist Pain | <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> Hormone Replacement |
| <input type="checkbox"/> TMJ Pain | <input type="checkbox"/> Digestive Ulcers | Therapy |
| | <input type="checkbox"/> Food Sensitivities | |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Chronic Constipation | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Chronic Diarrhea | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Headaches | | <input type="checkbox"/> Prostate Issues |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Severe PMS symptoms |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Erectile Dysfunction |
| <input type="checkbox"/> Pins/Needles | <input type="checkbox"/> Hearing Loss | |
| | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Chronic Ear Infections | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Heart Disease | | <input type="checkbox"/> Sudden weight gain/loss |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Skin Cancer | <input type="checkbox"/> OTHER _____ |
| <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Other Cancers _____ | _____ |
| <input type="checkbox"/> Easy Bruising | <input type="checkbox"/> Psoriasis | |
| <input type="checkbox"/> Angina | | |

FAMILY HISTORY

Relative	Health Condition/Illness
Mother	
Father	
Brother(s)	
Sister(s)	
Son(s)	
Daughter(s)	

Please list any previous injuries/surgeries _____

Are you pregnant or trying to become pregnant? Yes No



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Privacy Verification (Please check if you AGREE to the statement)

I may *request a copy* of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

Permission to Contact

I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

Payment Verification

I acknowledge that full payment is due at the time of service and I am responsible for any fees acquired from returned checks. I acknowledge that a 24-hour notice is required to cancel or reschedule an appointment and that I may be charged \$45 if such notice is not given. I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

General Verification

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

I acknowledge that I have had the opportunity to review the Notice of Privacy Practices on the date below on behalf of Scatko Family Chiropractic, PLLC.

Printed name of Patient _____

Signature of Patient _____

Date _____

Signature of Parent/Guardian (if minor) _____

Date _____

Doctor Use Only

Height: _____

Weight: _____

BP: ____/____