SCATKO FAMILY CHIROPRACTIC

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 _____ Gender *(check one)* ❑ Male ❑ Female

Address 1 _____

Address 2 _____

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 us to send appointment reminders to? *(check one)* ❑ Home ❑ Work

- **Marital Status** *(check one)* ❑ Single ❑ Married ❑ Other
- **Race** *(check one)*

❑ White ❑ Black/African American ❑ American Indian/Alaskan Native ❑ Asian

❑ Native Hawaiian or other Pacific Island ❑ Other_____ ❑ I choose not to specify

- **Employment Status** *(check one)*

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

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) _____

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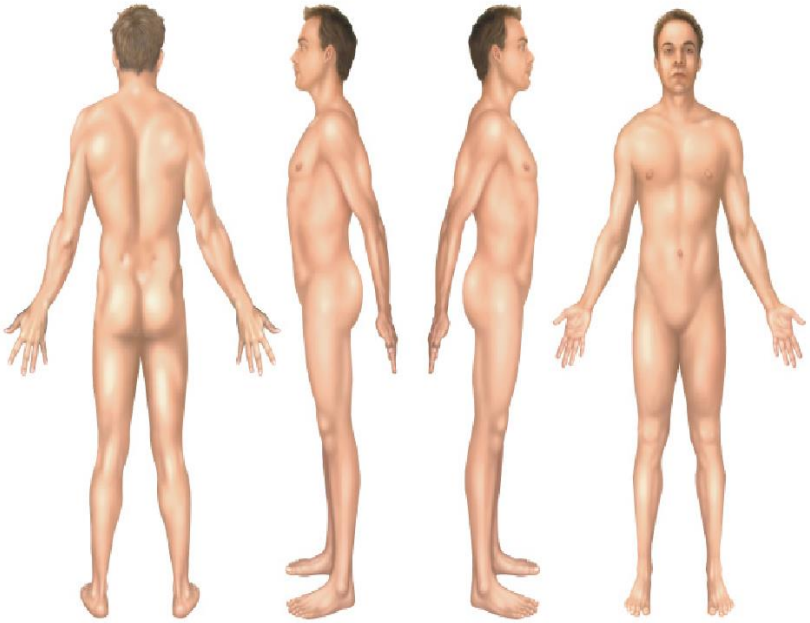
By using the key listed below, indicate on the body diagram where you are experiencing the following symptoms:

= Numbness X = Burning / = Stabbing 0 = Pins & Needles + = Dull Ache P = Pain



DOCTOR'S NOTES:

Describe your symptoms:_____

When did your symptoms start? Month_____ Day_____ Year_____

How did your symptoms begin?_____

Indicate the intensity of your symptoms 0 ---------- 10

No Pain Worst Pain

How often do you experience your symptoms? _____

Does it affect other areas of your body? To what extent does the pain radiate, shoot or travel? _____

_____

What makes it better or worse? Such as time of day, movements, certain activities, etc. _____

_____

Prior interventions- What have you done to relieve the symptoms?

❑ Prescription medication ❑ Acupuncture ❑ Over the counter medication ❑ Ice

❑ Homeopathic remedies ❑ Heat ❑ Physical therapy ❑ Chiropractic

❑ Massage ❑ Other _____

Is there anything else we should know about your current condition? _____

_____

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Review of Health History/Body Systems

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

- ☐ **Arthritis**
- ☐ **Osteoporosis**
- ☐ **Scoliosis**
- ☐ **Back Pain**
- ☐ **Neck Pain**
- ☐ **Hip Pain**
- ☐ **Knee Pain**
- ☐ **Foot/Ankle Pain**
- ☐ **Shoulder Pain**
- ☐ **Elbow/Wrist Pain**
- ☐ **TMJ Pain**

- ☐ **Anxiety**
- ☐ **Depression**
- ☐ **Headaches**
- ☐ **Dizziness**
- ☐ **Numbness**
- ☐ **Pins/Needles**

- ☐ **High Blood Pressure**
- ☐ **High Cholesterol**
- ☐ **Heart Disease**
- ☐ **Low Blood Pressure**
- ☐ **Poor Circulation**

- ☐ **Easy Bruising**
- ☐ **Angina**

- ☐ **Asthma**
- ☐ **Apnea**
- ☐ **Emphysema**
- ☐ **Shortness Breath**
- ☐ **Pneumonia**

- ☐ **Eating Disorders**
- ☐ **Digestive Ulcers**
- ☐ **Food Sensitivities**
- ☐ **Chronic Constipation**
- ☐ **Chronic Diarrhea**

- ☐ **Blurred Vision**
- ☐ **Ringing in Ears**
- ☐ **Hearing Loss**
- ☐ **Loss of Smell**
- ☐ **Loss of Taste**
- ☐ **Chronic Ear Infections**

- ☐ **Skin Cancer**
- ☐ **Other Cancers**
- ☐ **Psoriasis**
- ☐ **Eczema**
- ☐ **Hair Loss**

- ☐ **Thyroid Issues**
- ☐ **Immune disorders**
- ☐ **Low Energy**
- ☐ **Hypoglycemia**

- ☐ **Kidney Stones**
- ☐ **Infertility**
- ☐ **Prostate Issues**
- ☐ **Severe PMS symptoms**
- ☐ **Erectile Dysfunction**

- ☐ **Fainting**
- ☐ **Fatigue**
- ☐ **Weakness**
- ☐ **Sudden weight gain/loss**

FAMILY HISTORY

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

Please list any previous injuries_____

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 $20 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: _____/_____