

Lancaster Spinal Health Center

Please Print Clearly

Patient Name: _____ DOB: _____ Age: _____

Address: _____

Patient Social Security # _____ Parent SS # _____

Home Phone: _____ Cell _____ Work _____

Marital Status: S M D W Gender: M F Spouses Name: _____ Dob _____

If patient is a child – Name of Parent/Guardian _____ Dob _____

Address if different from child _____

Primary Insurance Company: _____

ID# _____ Group# _____

Name of Insured: _____ Date of birth _____

Employer _____ Work # _____

Secondary Insurance Company: _____

Chief Complaint: 1. _____

2. _____

3. _____

Are your present problems due to injury? Yes No On the job Auto

If so have you reported the accident/injury? Yes No

Family Doctor: _____ Chiropractor _____

Please give most recent date: Xrays _____

MRI _____

Family History:

Diabetes Heart Stroke Cancer Spine Arthritis

Mother _____

Father _____

Sister/brother _____

Habits:

Smoking: Yes No Alcohol: Yes NO Caffeine: Yes No Exercise: Yes No

Signature of Patient/Guardian _____

Signature of Insured _____
(Oct 2009)