Lakeside Chiropractic

Timothy B. Vyrostek, D.C. CCSP • 200 N. 3rd St., P.O. Box 169, Conneaut Lake, PA 16316
814.382.1970 Fax 814.382.3619

Please complete in blue or black ink

Confidential Patient Health Record/Reactivation ***Today's Date***: ___/____/_______

How did you hear about us? ☐ Family ________________ ☐ Friend ___________________ ☐ Co-Worker ________________
☐ Close to home/work ☐ Dr. ______________ ☐ Yellow pages ☐ Drove by ☐ Hospital ☐ Insurance Plan

Personal Information

Title: ☐ Mr. ☐ Ms. ☐ Mrs. ☐ Dr. ☐ Rev. ☐ Miss ☐ Prof. ☐ other: ___________________________________

Last:_____________________________ **First:**______________________________ **Middle:** _______________________________

Suffix: ☐ Jr ☐ Sr ☐ II ☐ III ☐ MD ☐ PhD ☐ DO ☐ Esq ☐ PA ☐ RN ☐ BSN ☐ other: _______________________

Birth Date: ____ /____/_______ **Age:**______ **Sex: Male / Female** **Social Security #:** _______-_______-________

Primary Language: ☐ English ☐ French ☐ German ☐ Spanish ☐ other: _______________________________________

Driver's License #: ___________________ **State:** _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Eye Color: ☐ blue ☐ brown ☐ green ☐ grey ☐ hazel ☐ other: __________

Hair Color: ☐ black ☐ blonde ☐ brown ☐ gray ☐ red ☐ white ☐ other: __________

Address: ____**Apt #** ______

City: ___________________ **State:** ______ **Zip:** __________ **Country:** ___________________ **County:** ______________

Home Phone: (_______) _______-__________ **ext** ______ **Work Phone:** (_______) _______-__________ **ext** ______

Cell Phone: (_______) _______-__________ **ext** ______ **Fax #:** (_______) _______-__________ **ext** ______

Email Address: ________________________________ **Spouses Name:** ___________________________________

Children (Names and Ages): ____

Emergency Contact

Title: ☐ Miss ☐ Mrs. ☐ Ms. ☐ Master ☐ Mr. ☐ Dr. ☐ Prof. ☐ Rev. ☐ other: __________________________________

Last:_____________________________ **First:**______________________________ **Middle:** _______________________________

Suffix: ☐ Jr ☐ Sr ☐ II ☐ III ☐ MD ☐ PhD ☐ DO ☐ Esq ☐ PA ☐ RN ☐ BSN ☐ other: _________________

Address: ____**Apt #** ______

City: ___________________ **State:** ______ **Zip:** __________ **Country:** ___________________ **County:** ______________

Relationship: ☐ Spouse ☐ Relative ☐ Friend ☐ Other _______________________

Home Phone: (_______) _______-__________ **ext** ______ **Cell Phone:** (_______) _______-__________ **ext** ______

Work Phone: (_______) _______-__________ **ext** ______ **Fax #:** (_______) _______-__________ **ext** ______

Employment Information

Business Name: ____

Address: ____Apt # ______

City: __________________ **State:** ______ **Zip:** _________ **Country:** __________________ **County:** _____________

Phone: (_______) _________-____________ **Fax #:** (_______) _________-____________

Employer's Email Address: ____________________________

Occupation/Job Title: __________________________ **Job Description** ______________________________________

Current Health Condition

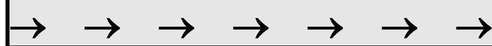
Unwanted Condition (Why you are here today?):_______________

____

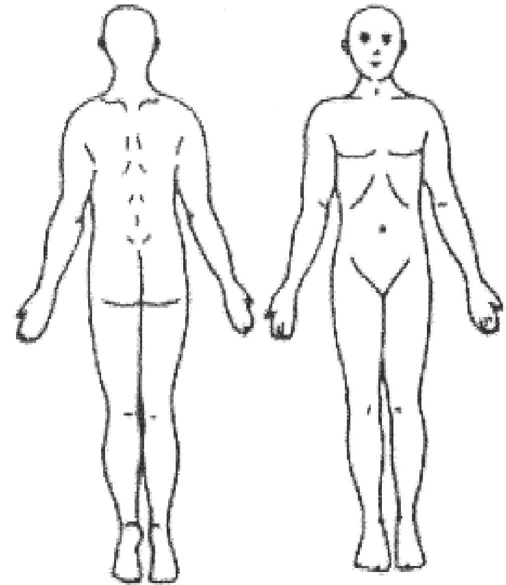
____

Use the letters BELOW to indicate the TYPE and LOCATION of your sensations right now.

PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT



Key: A=Ache B=Burning N = Numbness P=Pins & Needles S=Stabbing



When did this Condition BEGIN? _____/_______/_________

☐ **Immediately** ☐ **Hours Later** ☐ **Days Later** ☐ **Other**

Please Explain: ____

____

Has it ever occurred before? ☐ **Yes** ☐ **No. When?** ____________

Is the Condition: ☐ **Auto Related** ☐ **Job Related** ☐ **Home Injury**

☐ **Slip or Fall** ☐ **Lifting** ☐ **Slept Wrong** ☐ **Unknown Cause** ☐ **Other**

Explain: ____

____

____

Date of Accident: _________ **Time of Accident**: ________ **am /pm**

Do you SUFFER with ANY OTHER Condition than which you are now consulting us? ____

____

____

____

□ **I have NOT previously seen a Chiropractor for this condition.**
□ **I saw Dr.** _____________________ **Date of last visit:** _______________

□ **I have NOT seen my MD for this condition.**
□ **I saw Dr.** ____________________ **Type of Treatment:** ________________ **Did it help? Y/N**

Please tell us about your health history.
Surgery -including diagnosis (why) and date: ________________________________
____
Fracture including location and date: _____________________________________
____
Additional Diagnoses and Diagnosed by what Dr. (example: arthritis, diabetes, cancer)____
____

Current Medications:

Name	For What Condition	How long have you been taking ?

Have you been diagnosed with any condition in the area of (please circle yes or no):

Yes / No Sinus
Yes / No Lungs
Yes / No Heart
Yes / No Stomach
Yes / No Bowels
Yes / No Bladder
Yes / No Female/Male Reproductive Organs
Yes / No Allergy/Immunologic
Yes / No Neurologic
Yes / No Psychiatric
Additional ____________________
Additional ____________________

Please explain any yes: ____
____
____
____

Family History - Please check all that apply to any blood relatives.

☐ Arthritis ☐ Cancer ☐ Diabetes
☐ Fibromyalgia ☐ Heart Disease ☐ Spinal Stenosis
☐ Degenerative Joint Disease ☐ Degenerative Disc Disease
☐Osteoporosis ☐ Stroke/Vascular Disease

Continued on Back

Social History: Please check all that apply to you.

Tobacco Use: □ Have never smoked □ Former Smoker □ Current every day smoker □Current Occas Smoker □Have never used chew □Formerly used chew □ Currently use chew

Substance Use:□ never used illegal drugs □ not used illegal drugs since_____ □used i.d. for ______

Alcohol: □ Do not drink alcohol □social consumption only □ drink regularly (quantity) ____________

Insurance Information:

Who Is Responsible For Your Bill? YOU and… (mark appropriate box(es)) □ Myself ONLY

□ Spouse □ Worker's Comp □ Auto Insurance □ Medicare □ Other (be specific):_________________________

Personal Health Insurance Carrier: __________________ Health ID Card #: ____________________________

Policy Holder's Name: _____________________________ Group #: ____________________________________

Policy Holder's Social Security #: ______-_____-_______ Primary Care Physician: _______________________

Workers Compensation Injury / Auto / Personal Injury:

Have you filed an injury report with your employer? □Yes □ No Date:____/____/______Time: _______am/pm

Carrier: ____ Policy # _______________________________

Carriers Phone #: (_______) ___________-_______________ Adjuster: _______________________________

Claim #: ____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Chiropractic Clinic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Chiropractic Clinic will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the x-ray negative will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient Print Name: ____________________________ Patient's Signature: _________________________ Date: ___________
Consent to treat a Minor: ________________________________ Date: ______________
Guardian or Spouse's Signature of Authorizing Care: _________________________________ Date: ______________

I acknowledge that I have received the Chiropractic Clinic's Notice of Privacy Practices for protected health information.

Patient Print Name: ____ Date: ______________
Patient's Signature: ____ Date: ______________