Schneider Chiropractic, LLC
523 North Elm Street
Lincoln, IL 62656
(217) 732-2140

WELCOME

The doctor and staff of Schneider Chiropractic Office welcome you and want to provide you with the best possible care. We will conduct a thorough history and physical examination to decide if we can assist you. If we do not believe that your condition will respond to chiropractic care, we will not accept you as a patient but refer you to another health care provider, if appropriate.

PATIENT INFORMATION

Name (First, Middle, Last) _____ Date of Birth_____/_____/_____

Address_____ City, State, Zip_____, _____ _____

Social Security #:_____-_____-_____ Sex: _____Male _____Female Marital Status: _____Single _____Married _____Widowed _____Divorced

Race: _____ Language: _____ Name you preferred to be called in this office (nickname):_____

Home Phone: ( ) _____ Cell Phone: ( ) _____ Work Phone: ( ) _____ Ext: _____

Would you like to receive appointment reminders? (You may choose both options)

_____By Email (please provide your email address):_____

_____By Text Message-Cell phone number to receive the text: ( ) _____ Provider: _____

EMPLOYMENT INFORMATION

Employment Status: _____Employed _____Unemployed _____Retired _____Part-time Student _____Full-Time Student _____Other

Employer: _____Occupation:_____

RESPONSIBLE PARTY INFORMATION

Name (if other than self):_____Relationship to the Patient: _____

Address: _____City, State, Zip: _____, _____ _____

Responsible Party's Phone Number: ( ) _____

EMERGENCY CONTACT

Name: _____Relationship to Patient: _____

Phone Number for Emergency Contact: ( ) _____

IS YOUR ILLNESS RELATED TO ANY OF THE FOLLOWING?

_____Employment (Has your employer been notified? _____) _____Accident _____Auto Accident (State of Auto Accident_____)

Date of accident or injury: _____/_____/_____ Date symptoms appeared: _____/_____/_____ Have you ever had same condition? _____Yes _____No

List other practitioners you have seen for this injury/condition: _____

Have you ever been under chiropractic care? _____if yes, please describe_____

Please describe your injury: _____

HOW WERE YOU REFERRED TO OUR OFFICE?

_____By a Patient _____By a Doctor _____By an Attorney ____Radio Station _____Website or Internet _____Phone Book _____Location _____Other

Please print the name of your source: _____

ACCEPTANCE AS A PATIENT

I understand and agree that the doctor of Schneider Chiropractic, LLC has the right to refuse to accept me as a patient at any time before treatment begins, The taking of a history and conducting a physical examination are not considered treatment, but are part of the process on information gathering so that the doctor can determine whether to accept me as a patient.

Date: _____/_____/_____ Signature: _____