New Patient Information

Our Purpose at Peterson Chiropractic, PLLC is to educate as many families as possible about the spinal condition known as **Vertebral Subluxation. Vertebral Subluxation** destroys **Optimal Health.**

Your experience with our office will be one of healing, as well as, one of learning the truth about Optimal Health & Healing.

Please Complete All Questions

Name_____ Date_____

Address_____

City/State/Zip_____

Home Phone_____ Cell_____

Email address_____

I give Peterson Chiropractic, PLLC permission to send educational and informational notices to the above email. Peterson Chiropractic, PLLC agrees to keep the above email address confidential and will not share it with any other party.

Birth Date_____ Current Age_____ Social Security_____

Employer_____ Work Phone_____ Occupation_____

Spouse's Name_____ Spouse's Employer_____

Children Names & Ages_____

Your Favorite Hobbies_____

Who may we thank for referring you?_____

When did you last see a chiropractor?_____

Doctor's Name?_____

List other doctors you have seen recently-_____

Drugs taken-_____

Surgeries you have had-_____

Ever diagnosed with cancer?_____ What kind?_____

Who is financially responsible for this bill?_____

Emergency Contact-_____ Phone Number_____

What are your major complaints?_____

How do you want us to handle your problem?

____Temporary Relief (help the symptom, not the problem)

____Maximum Correction (correct the cause of the problem)

On a scale from 1-10 how important is your health to you?_____

*The vast majority of our patients have experienced literally dozens of impacts that could cause **Vertebral Subluxation**. Help us discover a few of yours.*

1. How many auto accidents have you been in? (please circle) Motorcycle accidents?
   0 1-2 3-4 5+ _____
2. Which of the following sports have you been involved in? (please circle)
   Football Basketball Baseball Soccer Hockey Gymnastics Martial Arts
   Dance Wrestling Horseback Riding Skating Water Skiing Other_____
3. Have you ever… (please check the box)
   [ ]Fallen down the stairs [ ]Had a stress or strain while working
   [ ]Slipped on ice or snow [ ]Had a sports injury
4. Do you… (please check the box)
   [ ]Sit more than four hours a day [ ]Drive more than two hours a day
   [ ]Work at a computer more than two hours a day
5. Are you? (please check the box)
   [ ]Computer Operator [ ]Assembly Line Worker [ ]Truck Driver
   [ ]Farmer [ ]Construction Worker [ ]Single/Working Mom/Dad
   [ ]Other_____

Subluxations can cause malfunction in any part of the body. Please check all the health complaints you are experiencing.

[ ]Neck Pain	[ ]Arm/Hand Problems	[ ]Ear Infections
[ ]Upper/Mid Back Pain	[ ]Leg/Foot Problems	[ ]Frequent Colds
[ ]Low Back Pain	[ ]Asthma	[ ]Digestive Problems
[ ]Headaches	[ ]Allergies	[ ]High Blood Pressure
[ ]Spinal Curvature	[ ]Sinus Problems	[ ]Diabetes

Subluxations can put pressure on nerves for a long time.
How long have you had the above problems?

Nerve pressure and irritation can be constant or occasional,
How often have you had the above complaint?

Irritation to different nerve fibers can create different sensations.
Is yours [ ]Sharp [ ]Dull [ ]Throbbing [ ]Achy [ ]Burning [ ]Tingling [ ]Numb [ ]Other

Subluxations can cause weakening of the entire spine. Is yours worse [ ]in the morning
[ ]late in the day [ ]at night [ ]all the time [ ]after activity?

Please Note:

1. All first visit charges are payable/due when services are rendered.
2. The fee paid for X-rays is for analysis only. The film itself is property of Peterson Chiropractic, PLLC.

I understand and agree that health and accident insurance policies are an arrangement between and insurance carrier and myself. Furthermore, I understand Peterson Chiropractic, PLLC will provide the necessary information to assist me in making collections from the insurance company and any amount authorized to be paid directly to Peterson Chiropractic, PLLC will be credited to my account. **However, I clearly understand and agree that I am personally responsible for payment due for services rendered.**

Signature_____Date_____
Guardian's Signature authorizing Minor's care_____