 Dr. Kristen Peeters, CACCP

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 (315)302-1230

**PERSONAL INFORMATION:**

 Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age:\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City/State/ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Home Phone #: (\_\_)\_\_\_\_-\_\_\_\_\_ Work Phone #: (\_\_)\_\_\_\_-\_\_\_\_\_ Cell Phone #: (\_\_)\_\_\_\_-\_\_\_\_\_\_

 Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Male \_\_\_\_\_ Female: \_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employer Name and Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Best Time to Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Status: Single Married Divorced Widowed

 # of Children, Names and Ages: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Whom may we thank for referring you to our office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**YOUR HEALTH:**

***Please place an “X”*** *on the scale above marking where you believe your level of health and wellness is at this time.*

***Place an “0”*** *on the diagram indicating where you would* ***like*** *your health and wellness to be.*

 **YOUR HEALTH PROFILE:**

What brings you into our office? Please briefly describe your chief concern, including the impact it has had on your life. If you have no symptoms or complaints and are here for Chiropractic Wellness Services, please skip to the “General History” page.

**Health** Rate Severity When did Are symptoms Did problem **Concerns:** 1 = mild this start? Constant or begin with injury?

 10= worst imaginable intermittent?

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



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 **Since the problem started, it is**…\_\_\_\_The Same \_\_\_\_\_Getting Better \_\_\_\_\_Getting Worse

**What makes the problem worse?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**What, if anything, makes it feel better?** \_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Does this interfere with your:** \_\_\_\_Work \_\_\_\_Leisure \_\_\_\_Sleep \_\_\_\_Sports \_\_\_\_Other:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you seen other doctors for this condition?** \_\_\_Chiropractor \_\_\_ Medical Dr.\_\_\_Other

 Name/ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_What was diagnosis? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Name/ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_What was diagnosis? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**General History:**

 **List all medications you are taking and why: (Prescription and non-prescription)** \_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Have you had any surgeries or hospitalizations? (Please include all surgeries)**

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 **What do you do for a living?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Have you ever had any work related injuries?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Have you ever had any slips, falls or auto accidents?**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 **Please check (✓) all symptoms you have ever had, even if they do not seem related to your current problem:**

􀃍 Headaches 􀃍 Pins and needles in legs 􀃍 Fainting 􀃍 Neck pain

􀃍 Pins and needles in arms 􀃍 Loss of smell 􀃍 Back Pain 􀃍 Loss of balance

􀃍 Dizziness 􀃍 Buzzing in ears 􀃍 Ringing in ears 􀃍 Nervousness

􀃍 Numbness in fingers 􀃍 Numbness in toes 􀃍 Loss of taste 􀃍 Stomach Upset

􀃍 Fatigue 􀃍 Depression 􀃍 Irritability 􀃍 Tension

􀃍 Sleeping problems 􀃍 Stiff Neck 􀃍 Cold Hands 􀃍 Cold Feet

􀃍 Diarrhea 􀃍 Constipation 􀃍 Fever 􀃍 Hot Flashes

􀃍 Cold Sweats 􀃍 Lights bother eyes 􀃍 Urinary Problem 􀃍 Heartburn

􀃍 Mood Swings 􀃍 Menstrual Pain 􀃍 Menstrual Irregularity 􀃍 Ulcers

**On a scale of 1-10 describe your psychological/emotional stress levels:**

(1= none/ 10=extreme)

Occupational: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Personal: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**On a scale of 1-10, (1 being very poor and 10 being excellent) describe your:**

Eating habits: \_\_\_\_\_Exercise habits:\_\_\_\_\_ Sleep: \_\_\_\_\_ General Health: \_\_\_\_\_ Mind-set:\_\_\_\_\_

**YOUR GOALS:** At our office we concern ourselves with YOUR health and YOUR wellness goals. Please list your goals for your health and wellness in the spaces provided.

 **Physical Goals: Nutritional/ Biochemical Goals: Psychological Goals:**

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you ever:**

Bought bottled water: 􀃍 Yes 􀃍 No

Belonged to a health club: 􀃍 Yes 􀃍 No

Consumed vitamins or supplements 􀃍 Yes 􀃍 No

If there is a need for dietary changes would you like to know? 􀃍 Yes 􀃍 No

If there is a need for specific exercises would you like to know? 􀃍 Yes 􀃍 No

If there is a need for support in the psychological/mind/body/stress

dimension of health would you like assistance? 􀃍 Yes 􀃍 No

I consent to a professional and complete chiropractic examination, which may include being sent out for a radiographic examination, that the doctor deems necessary. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Thank you for choosing Lifetime Family Chiropractic.***

***We appreciate the opportunity to help you and your family to achieve better health.***