NEW LIFE FAMILY Chiropractic

Dr. Christina Petersen 132 Park Avenue New City, NY 10956 (845)517-0520

Welcome!

Date:_____

Name: _____

Address: _____

City: _____ State_____ Zip Code_____

Email: _____ Phone #: _____

Date of Birth: _____ Cell Phone Carrier for Texting: _____

Referred by: _____

Primary care doctor: _____

Occupation: _____ Your employer's name: _____

Relationship status: _____

Significant other's name: _____

Significant other's occupation: _____

Children's name and ages: _____

Health

Health concerns: _____

Have you had the same or similar concerns in the past? _____

Parents/siblings and children with similar concerns? _____

Is this the result of an auto or work injury? _____

Date of accident or injury: _____

What other forms of treatment have you tried? _____

Surgeries: _____

Medications:_____

Supplements:_____

Are you pregnant? Yes / No

Have you ever been diagnosed with cancer?_____

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Lifestyle

Describe your diet: _____

Do you drink adequate water during the day? _____

Are you exposed to toxins on a regular basis? _____

Personal care products * candles fumes * cleaning products * plastics

How would you describe your stress level: _____

Describe daily/weekly physical activity level: _____

Describe your exercise routine: _____

How many hours a night do you sleep?_____

Which of the following statements best describes your expectations of chiropractic care? Please check all that apply.

____ Relief of symptom or problem only ____ Relief and prevention of symptom or problem

____ Healthier spine and nerve system ____ Optimal health on all levels

List your hobbies and interest:_____

_____

Additional information you would like to share with Dr. Chrissy:_____

_____

_____

Insurance

Do you expect your health insurance to pay or contribute to your care? yes/no

Name of insurance carrier:_____

Healing starts here!