

**Karl Peterson D.C., N.D**  
**CONSULTATION ADMITTANCE**  
*(please print)*

**CONFIDENTIAL PATIENT INFORMATION**

DATE \_\_\_\_\_  
NAME \_\_\_\_\_ Spouse \_\_\_\_\_  
ADDRESS \_\_\_\_\_ CITY/ST/ZIP \_\_\_\_\_  
PHONE (home) \_\_\_\_\_ (work) \_\_\_\_\_ (cell) \_\_\_\_\_  
AGE \_\_\_\_\_ BIRTHDATE \_\_\_\_/\_\_\_\_/\_\_\_\_ S.S.# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ HOW MANY CHILDREN \_\_\_\_\_  
YOUR EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_  
EMPLOYER ADDRESS \_\_\_\_\_ CITY/ST/ZIP \_\_\_\_\_  
MARITAL STATUS: S M W D Sep SPOUSE'S EMPLOYER \_\_\_\_\_  
REFERRED TO OUR OFFICE BY \_\_\_\_\_  
CHIEF COMPLAINT \_\_\_\_\_  
WHEN DID IT START \_\_\_\_\_ is it worse \_\_\_\_\_ same \_\_\_\_\_ better \_\_\_\_\_  
OTHER DOCTOR(S) SEEN FOR THIS CONDITION \_\_\_\_\_  
DATE OF LAST PHYSICAL EXAM \_\_\_\_\_ WHERE \_\_\_\_\_

**FAMILY HISTORY:**

KEY: M-mother F-father B-brother S-sister SELF-self

Rheumatic Fever _____	Emphysema _____	Heart Disease _____	Sleep Loss _____
Tuberculosis _____	Difficult Breathing _____	Diabetes _____	Hemorrhoids _____
Cancer _____	Asthma _____	Kidney Disease _____	Backaches _____
Pneumonia _____	Allergies _____	Liver Disease _____	Nervousness _____
Blood Pressure _____	Ulcers _____	Nerve Disease _____	Headaches _____
Diverticulitis _____	Colitis _____	Urinary Problems _____	Dizziness _____
Bowel Problems _____	Arthritis _____	Sinus _____	Migraines _____

HIV positive: (yes) \_\_\_\_\_ (no) \_\_\_\_\_ Other conditions \_\_\_\_\_

Have you been treated for any other health conditions this year? (yes) \_\_\_\_\_ (no) \_\_\_\_\_  
What? \_\_\_\_\_

What SURGERY have you had? Tonsils \_\_\_\_\_ Appendix \_\_\_\_\_ Gall Bladder \_\_\_\_\_ Hemorrhoids \_\_\_\_\_  
Vasectomy \_\_\_\_\_ Hysterectomy (partial) \_\_\_\_\_ (complete) \_\_\_\_\_ Other surgery \_\_\_\_\_

Have you ever had any bad falls? (yes) \_\_\_\_\_ (no) \_\_\_\_\_ When? \_\_\_\_\_  
Describe: \_\_\_\_\_

Have you ever broken any bones? (yes) \_\_\_\_\_ (no) \_\_\_\_\_ When? \_\_\_\_\_  
Describe: \_\_\_\_\_

Have you ever been in a car accident? (yes) \_\_\_\_\_ (no) \_\_\_\_\_ When? \_\_\_\_\_  
Describe: \_\_\_\_\_

What medications or drugs are you taking? \_\_\_\_\_

List names of other Chiropractors or Naturopaths seen? \_\_\_\_\_

Name of person responsible for payment? \_\_\_\_\_

Are you insured? (no) \_\_\_\_\_ (yes) \_\_\_\_\_ Insurance Co: \_\_\_\_\_ ID # \_\_\_\_\_  
Insured name: \_\_\_\_\_ Group # \_\_\_\_\_

*\*Please show your INSURANCE ID CARD to receptionist.*

*I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Dr. Peterson will prepare any necessary reports and forms to assist me in making collection from the insurance company. I clearly understand and agree that all services rendered me that my insurance carrier does not cover I am personally responsible to pay. I further agree to a finance charge of 1% monthly on all past due accounts. PAYMENT IS EXPECTED AT TIME OF VISIT.*

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

DRIVER'S LICENSE # \_\_\_\_\_ (STATE: \_\_\_\_\_)