



# Dr. Jennifer Peet

Chiropractic for Kids & Adults

2882 Shelburne Road

Shelburne, VT 05482

Welcome. To help us help you, please complete each section below fully.

Name \_\_\_\_\_ Date \_\_\_\_\_ Preferred Name \_\_\_\_\_  
 Address \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 City/State/Zip \_\_\_\_\_ Place of Employment: \_\_\_\_\_  
 E-mail Address \_\_\_\_\_ Soc. Sec.#: \_\_\_\_\_  
 Telephone No.'s (h) \_\_\_\_\_ (w) \_\_\_\_\_ (c) \_\_\_\_\_  
 Marital Status: (check one)  Single  Married  Separated  Divorced  Widowed  
 Children's Names & Ages \_\_\_\_\_

## Insurance Information

Name of Insurance Company \_\_\_\_\_  
 Address \_\_\_\_\_ Telephone \_\_\_\_\_  
 ID/Policy No. \_\_\_\_\_ Group No. \_\_\_\_\_  
 Insured's Name \_\_\_\_\_ Relationship to Insured \_\_\_\_\_

## Patient History

What would you like to see the doctor for? \_\_\_\_\_  
 Please describe your symptoms if you have any: \_\_\_\_\_  
 When did these problems start? \_\_\_\_\_  
 How often do these problems occur? \_\_\_\_\_  
 If in pain, at what level is it from 1-10 with a 10 being the absolute worse it could be? \_\_\_\_\_  
 Any recent accidents/falls/injuries (describe)? \_\_\_\_\_  
 Is there anything that aggravates or relieves your symptoms? \_\_\_\_\_  
 \_\_\_\_\_  
 What other treatments/medications have you sought for this problem? \_\_\_\_\_  
 \_\_\_\_\_  
 Any other health concerns/complaints? \_\_\_\_\_  
 Any recent illnesses/injuries? \_\_\_\_\_  
 Any past surgeries/hospitalizations? \_\_\_\_\_  
 Are you currently on any medications, if so what? \_\_\_\_\_  
 Have you had Chiropractic Care before? Y/N If yes name of Doctor of Chiropractic? \_\_\_\_\_  
 When was your last adjustment? \_\_\_\_\_ How often were you seen? \_\_\_\_\_  
 Your Height? \_\_\_\_\_ Your Weight? \_\_\_\_\_ Any recent Weight Loss or Gain? \_\_\_\_\_  
 How did you hear about our office? \_\_\_\_\_ Whom may we thank? \_\_\_\_\_

## Family History

Do you have a family history of (check all that apply):  Heart Trouble  Cancer  Diabetes  
 Nervous Conditions  Arthritis  Depression  Inherited Diseases  Kidney Disease  Others: \_\_\_\_\_

## Occupational/Student Information

What's your occupation? \_\_\_\_\_ How many hours a week do you work/go to school? \_\_\_\_\_  
 Is your work/sports physically demanding? Y/N If yes, how so \_\_\_\_\_  
 Is your work/school stressful? Y/N If yes, how so \_\_\_\_\_

**- PLEASE TURN OVER AND COMPLETE -**

Office Use Only

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

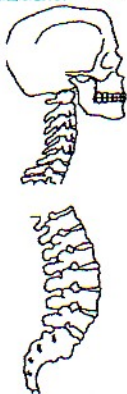
AST \_\_\_\_\_

C Phase: \_\_\_\_\_

L Phase: \_\_\_\_\_

Leg Length: \_\_\_\_\_ mm

T1  
T2  
T3  
T4  
T5  
T6  
T7  
T8  
T9  
T10  
T11  
T12  
L1  
L2  
L3  
L4  
L5  
S



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

Notes: \_\_\_\_\_

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

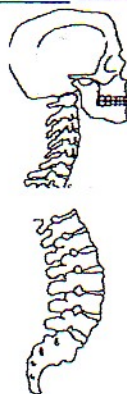
AST \_\_\_\_\_

C Phase: \_\_\_\_\_

L Phase: \_\_\_\_\_

Leg Length: \_\_\_\_\_ mm

T1  
T2  
T3  
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T7  
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T12  
L1  
L2  
L3  
L4  
L5  
S



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

Notes: \_\_\_\_\_

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

AST \_\_\_\_\_

C Phase: \_\_\_\_\_

L Phase: \_\_\_\_\_

Leg Length: \_\_\_\_\_ mm

T1  
T2  
T3  
T4  
T5  
T6  
T7  
T8  
T9  
T10  
T11  
T12  
L1  
L2  
L3  
L4  
L5  
S



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

Notes: \_\_\_\_\_

CARE PLAN

1. Patch Care:

3 Visits weekly for \_\_\_\_\_ weeks

2 Visits weekly for \_\_\_\_\_ weeks

1 Visit weekly for \_\_\_\_\_ weeks

Re-x-ray/Reexamination on \_\_\_\_\_ Visit

2. Fix (or correct as much as possible) Care:

3 Visits monthly for \_\_\_\_\_ months

2 Visits monthly for \_\_\_\_\_ months

1 Visit monthly for \_\_\_\_\_ months

Re-x-ray/Reexamination on \_\_\_\_\_ Visit

GOALS OF CARE: \_\_\_\_\_

Daily Notes: \_\_\_\_\_