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Member
National Board of
Chiropractic Examiners
Georgia Chiropractic
Association Georgia
Georgia Chiropractic Council

Please check the type of care desired: Temporary relief: Lasting correction
Check here if you want the doctor to recommend the best type of care for you

Name _____ Date of birth _____ SS# _____

Address _____ City _____ ST _____ Zip _____

Home# _____ Work# _____ Cell _____ Email _____

How would you like us to remind you of your appointments? Home Work Cell Email

Sex: M F

Married Single Separated Divorced Widowed Spouse Name _____

Patient employed by _____ Spouse employed by _____

Name of nearest relative _____ Phone# _____

In case of emergency who should be notified _____ Phone# _____

Family doctor _____ Phone# _____ Are you pregnant

Whom may we thank for referring you _____

Your condition developed from: Auto injury Work injury Sports injury

Slip/fall Lifting Surgery Pregnancy Not Sure

Primary Insurance

Person Responsible for care: Self/Cash Health Ins Auto Ins
Medicare Work Comp

Name of insurance: _____ Member # _____ Group # _____

Assignment and Release

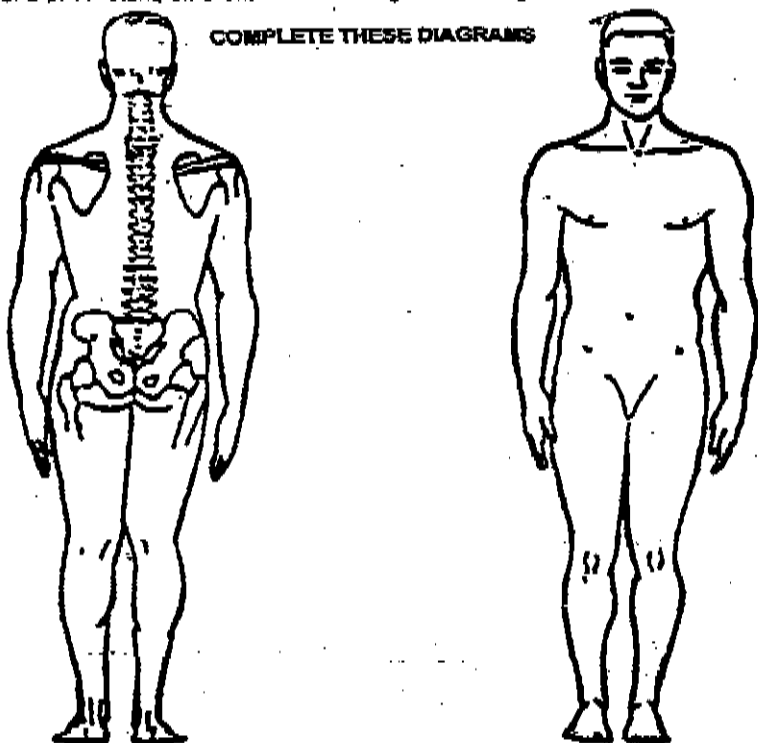
I, the undersigned, certify that I have insurance with _____ and assign directly to Dr. Evans P. Peters all insurance benefits (if any) otherwise payable to me for services rendered. I understand that I am financially responsible for all charges incurred by me, whether or not paid by the insurance company. I authorized Dr. Evans P. Peters to release information and use any signature on all insurance submissions. A \$10.00 Missed appointment fee will be charged for failure to keep your appointment without a 24 hour notice.

Signature

Date

If you are in pain, please mark the exact location of your pain on the diagram below. Also describe the type and frequency of your pain, as well as any activity which brings on or aggravates the pain. For example, dull, sharp, constant, off & on, when standing, when sitting, etc., etc.

COMPLETE THESE DIAGRAMS



Please describe your condition:

How long have you had this condition?

How did this condition develop?

Have you had prior similar symptoms?

Treatment received for this condition?

Is your condition better, worse or same? _____

Have you lost any work due to your condition? _____

Type of work you do? _____

Is there anything that aggravates your condition?

What makes your condition feel better?

Have you been in a prior auto accident? If yes, what were your injuries?

Prior surgery for any condition:

Prior chiropractic care, if yes please provide name of doctor:

Last visit to your chiropractic: _____

Last time you had spinal x-rays: _____

FOR DOCTOR USE ONLY

Current Rx: _____
 Referral Dr.: _____
 Surgical Indications: _____
 Contraindications: _____
 MRI, CT, EMG, EEG, Rehab: _____

Onset: _____
 Prov. Fact: _____
 Quality: _____
 Radicular: _____
 Severity: _____
 Duration: _____