



Welcome

807 N Sullivan Rd Ste 1
Spokane Valley WA 99037
www.b2bwa.com

Confidential Patient Information

Please fill in as completely as possible.

Thank you!

First Name:		M.I.	Last Name:		Name You Like to be Called:		Age:
Street Address:				City:		Zip Code:	
Home Phone:		Work Phone:		Other phone:		E-mail:	
Sex:	Birth date:	Marital Status: S M W D		Spouse's Name:		No. of Children:	
Will you be using insurance to cover care?			Health?	Work/Comp?	Auto?	Medicare?	Other?
Insured's Name:		SS#:	Date of Birth:	Relation:	Employer:		

History	What caused your problem? When?							
	Health Problem or Purpose for Visit:							
About Your Problem	Is your problem due to: Auto Accident? Work Injury? Other Accident? Stress? Illness? Other?							
	Date symptoms appeared?	Are they: Improving? Getting Worse? Same? Come & Go?						
	What have you done for this condition?							
	What can't you do because of this condition that you want to do?						↓ Mark areas of symptoms ↓	
	What things in your do you enjoy less because of your problem?							
What other problems has your condition caused?								

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. I authorize payment from my insurance carrier directly to Dr. Peters with the understanding that all monies will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, that fees for professional services rendered me will be immediately due and payable. In the event of default I promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees as may be required to effect collection

Patient Signature

Date

Over please



About Your Health	The human body is designed to be healthy. There are, however, certain essential ingredients required for the maintenance of good health. There are also events that can occur throughout life that can damage your health potential. Here we will explore these areas.			
	Please rate the following health practices on a scale of 1-10		Joyful, optimistic attitude: 1 2 3 4 5 6 7 8 9 10	Attention to spiritual health: 1 2 3 4 5 6 7 8 9 10
	Fresh, good quality food: 1 2 3 4 5 6 7 8 9 10	Daily vigorous exercise: 1 2 3 4 5 6 7 8 9 10	Adequate, quality rest: 1 2 3 4 5 6 7 8 9 10	Plenty of pure water: 1 2 3 4 5 6 7 8 9 10
	Loss of wellness - Please check all that apply	Birth process:	Childhood:	Adult:
		<input type="checkbox"/> Difficult delivery <input type="checkbox"/> Induced labor <input type="checkbox"/> Forceps/extraction <input type="checkbox"/> C-Section <input type="checkbox"/> Breach <input type="checkbox"/> Home birth <input type="checkbox"/> Hospital birth	<input type="checkbox"/> Breast fed <input type="checkbox"/> Childhood illness <input type="checkbox"/> Ear infection/ colic/ asthma/ allergies <input type="checkbox"/> Accidents/ falls <input type="checkbox"/> Attention deficit <input type="checkbox"/> Vaccination	<input type="checkbox"/> Occupational stress <input type="checkbox"/> Mental/emotional stress <input type="checkbox"/> Physical stress <input type="checkbox"/> Accidents/ injury <input type="checkbox"/> Surgery <input type="checkbox"/> Drugs
	Symptoms -	<input type="checkbox"/> Headaches <input type="checkbox"/> Neck pain <input type="checkbox"/> Pain between shoulders <input type="checkbox"/> Shoulder pain <input type="checkbox"/> Pain in hands/ arms <input type="checkbox"/> Numbness in hands/ arms <input type="checkbox"/> Sleeping problems <input type="checkbox"/> Tension <input type="checkbox"/> Irritability <input type="checkbox"/> Dizziness	<input type="checkbox"/> Low back pain <input type="checkbox"/> Leg pain <input type="checkbox"/> Leg/ foot numbness <input type="checkbox"/> Knee pain <input type="checkbox"/> Foot pain <input type="checkbox"/> Fatigue <input type="checkbox"/> Depression <input type="checkbox"/> Asthma <input type="checkbox"/> Allergies <input type="checkbox"/> Arthritis <input type="checkbox"/> Autoimmune disease	<input type="checkbox"/> Chest pain <input type="checkbox"/> Heart attack <input type="checkbox"/> High blood pressure <input type="checkbox"/> Stroke <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Stomach upset <input type="checkbox"/> Menstrual cramps <input type="checkbox"/> Sinus
	What drugs are you taking? <input type="checkbox"/> None			
	What surgeries have you had? <input type="checkbox"/> None			
	What side effects have you experienced from drugs and/or surgery?			
	What do you hope to accomplish in our work together?			
Why do you brush / floss / get teeth cleaned? (There's a good reason for this strange question.)				

Emergency Contact Info	
Who should we contact?	Relation?
Phone #:	2 nd Phone #: