



Welcome To Four Points Family Chiropractic
New Patient Form
 Please complete all questions.

Name:		Date:
Address:		City/State/ZIP:
Home Phone:	Work Phone:	Cell Phone:
Birth date:	Age:	Social Security #:
Marital Status: M W D S	E-mail address:	
Your Employer:		Occupation:
Spouse's Name:		Spouse's Employer:
Children's Names and Ages:		
Favorite Hobbies or Interests:		
Emergency Contact Person and Phone #:		

Current health concerns/reasons for consulting our office:

1. _____
2. _____
3. _____
4. _____

Who may we thank for referring you? _____

Have you had same or similar problem(s) before? _____

If so, for how long? _____

Is this the result of an auto or work injury? _____ If so, when? _____

Father, mother, brother, sister, children with similar problems? _____ If so, who? _____

Other doctors you have seen for this problem: _____

Surgeries you have had: _____

Medications you currently take: _____

Is there any chance you are pregnant? _____

Have you ever been diagnosed with cancer? _____ If so, what kind? _____

Do you have health insurance? _____ Name of company: _____

Policy # _____ Policy holder _____

(over)



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Stress Test

The following areas of stress can cause misaligned vertebrae (Subluxation).

Which of these stresses do you recognize?

Please circle when you experienced these stresses:

Child=C, Teenager=T, Adult=A

Physical/ Emotional/ Chemical Stress:

Comments:

Birth Trauma	C			
Slips or Falls	C	T	A	
Automobile Accidents	C	T	A	
Sports Injuries	C	T	A	
Physical Abuse	C	T	A	
Poor Posture	C	T	A	
Work Injuries		T	A	
Extensive Computer Work		T	A	
Sleeping on Stomach		T	A	
Sitting on a Wallet		T	A	
Carrying a Heavy Purse/ Bookbag/ Child		T	A	
Repetitive Lifting/ Bending		T	A	
Driving for Many Hours		T	A	
Continuous Hours Sitting/ Standing		T	A	
Children Stress		T	A	
Career Stress			A	
Relationship Stress	C	T	A	
Concealed Feelings	C	T	A	
Quick Tempered	C	T	A	
Smoker/ 2 nd Hand Smoke	C	T	A	Amount: _____
Poor Diet/ Excessive Sugar	C	T	A	Amount: _____
Caffeine	C	T	A	Amount: _____
Artificial Sweeteners	C	T	A	
Prescription Drugs	C	T	A	
Over The Counter Drugs (eg. Tylenol, Motrin, etc.)	C	T	A	

Which do you feel are your primary stresses? _____.

The above information is true and accurate to the best of my knowledge.

Patient or Guardian Signature: _____ Date: _____