Crossroads Family Chiropractic
Nutrition Response Testing
NEW PATIENT INFORMATION FORM

Patient ID _____

Please print clearly:

Name_____ Date_____

Address_____ Apt.#_____

City_____ State_____ ZIP_____

Shipping Address_____

Cell Phone (____) ____-_____ Work Phone (____) ____-_____

e-mail address: _____

REFERRED BY:_____

***Do we have your permission to reach out to thank them? Y / N**

***Would you like to receive our Crossroads Newsletter? Y / N**

(Contains whole food recipes, health devotionals, and office updates/promotions)

***Would you like to receive text reminders for scheduled appointments? Y / N**

If so, who is your service provider? _____

Occupation_____ Employer_____

Date of Birth_____ Age ____ Sex: M/F Height _____ Weight _____

Overall health (circle one): Excellent / Good / Fair / Poor / Other:

Chief complaint (reason you are here): (use separate sheet if more room needed)_____

_____

Previous treatments for this complaint_____

_____

Other complaints or problems: (use separate sheet if needed)_____

_____

Current medications/drugs being taken: (use separate sheet if needed)_____

_____

Are you currently under the care of a physician or other health care professionals?_____

(If yes, please give name and date of last visit):_____

Nutritional supplements you are taking:_____

_____

Do you smoke, drink coffee or alcohol? (if yes indicate how much)

Cigarettes _____ Coffee _____ Alcohol _____

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Office Use Only:

 Patient ID _____

Name:_____ Date_____

HISTORY:

List any major illnesses (with approx. dates):_____

_____

List any surgery or operations with approx. date:_____

_____

Past Accidents or injuries:_____

_____

_____

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Marital Status: S M D W Name of Spouse_____

Describe health of spouse:_____ Number of children if any _____

Name of Child	Age	Sex	Any physical conditions or concerns?
_____	____	M/F	_____
_____	____	M/F	_____
_____	____	M/F	_____
_____	____	M/F	_____
_____	____	M/F	_____
_____	____	M/F	_____

Any family history of serious illnesses (circle those which apply): Cancer / Diabetes / Heart / Other _____

Any household pets or other animals you or family members are in close contact with:__

_____

What can we do to make you happier?_____

_____

_____

SIGNED:_____ DATE:_____