

Turley Chiropractic Clinic

New Patient Confidential Information

Name _____ Date _____ SS# _____
Address _____ City _____ State _____ Zip _____
Seasonal Address _____ City _____ State _____ Zip _____
Age _____ Birthdate _____ Male Female Married Single Widowed Divorced Separated
Home Phone _____ Cell Phone _____ Email Address _____
Employer _____ Occupation _____ Work # _____
Business Address _____ City _____ State _____ Zip _____
Spouse/Parent's Name _____ Birthdate _____ Phone# _____
Emergency Contact _____ Phone# _____ Relation _____
Whom may we thank for referring you to us? _____
Or did you see us on the internet? Google _____ Yellow Pages.com _____ Other? _____
Name of local primary care Physician: _____
May we contact them? _____ Physician's Phone# _____

Symptoms

Main Complaint _____
When did it start? _____ Getting Worse? _____ Getting Better? _____
What activity bothers it most? _____
When is it at its best? _____ When is it at its worst? _____
Secondary Complaints _____
Other Chiropractors? _____ Positive Experience? _____
Other type of physician or therapist? _____ Positive Experience? _____

Health History – please circle all that apply

AIDS/HIV	Cataracts	Goiter	Miscarriage	Sinus Trouble
Allergies	Chronic Fatigue	Gout	Mono	S.T.D.
Anorexia	Chicken Pox	Heart	M.S.	Stroke
Anxiety	Chronic Fatigue	Hepatitis	Mumps	Thyroid
Appendicitis	Clotting Trouble	Hernia	Neuritis	Tonsillitis
Arthritis	Depression	Herniated Disc	Osteoporosis	Tuberculosis
Asthma	Diabetes	High Blood Pressure	Pacemaker	Tumors
Backaches	Digestive Disorders	High Cholesterol	Parkinson's	Typhoid
Bleeding	Emphysema	Implants	Pneumonia	Ulcers
Breast Lump	Epilepsy	Kidney	Polio	Whooping Cough
Bronchitis	Fibromyalgia	Liver	Prostate	Other _____
Bulimia	Fractures	Measles	Prosthesis	
Cancer	Glaucoma	Migraines	Rheumatoid	

Women Only: How many children? _____ Pregnant? _____ Nursing _____ Taking Birth Control? _____
Date of last menstrual cycle _____

Previous Surgeries and Dates: _____

List ALL medications you are currently taking: _____

What kind of exercise do you do? _____

What supplements do you take? _____

How much do you smoke per day? _____ Drink per week? _____

Was your injury/incident accident related? _____ (If **yes**, please tell receptionist after completing this form)
Have you lost any days of work? _____ (If **yes**, give dates: _____)

PAYMENT IS EXPECTED AT TIME OF VISIT! Will you be paying by: Cash Credit Card Check
Are you insured? _____ Company _____
(If **yes**, please provide the receptionist with a copy of your insurance card)

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that TURLEY CHIROPRACTIC CLINIC will provide an itemized statement and/or prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to TURLEY CHIROPRACTIC CLINIC will be credited to my account on receipt. However, I clearly understand and agree that any 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, any fees for professional services rendered me will be immediately due and payable.

I understand and agree that all the above questions have been answered accurately, and I understand that giving incorrect information can be dangerous. I authorize this office to release any information pertaining to my treatment to third party payers or other health care providers. I authorize and request my insurance company to pay directly to this office any payable benefits. I further understand that payment may be less than the actual cost of services and will be responsible for any outstanding amount owed this office.

Patient's Signature: _____ Date: _____

Guardian or Spouse's Signature: _____ Date: _____

Information Taken By: _____ Date: _____