Turlock Chiropractic Center

Patient Introduction

All Information is Confidential

Your Name: _____
First Middle Last

Your Address:_____
Your City, State, Zip:_____
Your Home Telephone:_____
Your Work Telephone:_ _____
Your Cell Telephone:_____

E-Mail Address: _____
Insurance Card:_____
(Please bring health card to front desk)
Social Security Number:_____
Birth Date: Month: _____ Day: _____ Year: _____
Marital Status:_____Spouses Name:_____
Your Occupation:_____
Your Employer:_____

Previous Chiropractor: _____ City: _____
Last visit to this Chiropractor:_____
Reason for leaving:_____
Present MD: _____ City: _____

Referred to our office by:_____

THANK YOU!

Adult Consultation History

Your Name: _____
Your Main Complaint: _____
Any other Complaints: _____
How long have you suffered with this problem? _____
What have you tried to do to get rid of this problem that **DID NOT** work? _____
_____
Have you become discouraged about handling this problem? _____
When your problem is at its worst, how does it make you feel? _____
Does this problem interfere with the following areas of your life?

FAMILY: _____

HOBBIES: _____

LIFE: _____

Does handling this problem cause stress for you? _____

What do you do that makes this problem worse? _____

How much older does this make you feel: _____

On a scale of 1-10, with 10 being the highest, rate your commitment in helping us solve this problem: ____

What gives you some temporary relief? _____

What is the pattern of this problem? ☐ Constant ☐ Intermittent ☐ Occasional ☐ Cyclic
What is the effect it has on your body functions? _____
How did it start? _____
Are you on any type of medication?_____, Please list all: _____
Could your problem have been caused by an injury at work? _____
If yes, please give us the details: _____
Have you been involved in an auto accident?_____
Date of accident? _____
Any difficulties from this? _____
Do you have any children? _____
Do they have any health problems that you are aware of? _____
_____
Is there any other information you would like us to know? _____
_____

For Women Only:
Date of your last menstrual period: _____
Are you using any means of contraception? _____
Do you experience severe cramping with your menstrual period? _____
Do you suffer from PMS? _____

PATIENT SIGNATURE: _____ DATE: _____

THANK YOU!

Turlock Chiropractic Center
991 E. Monte Vista Ave, Suite 2
Turlock, CA 95382
(209) 632-3662

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Consent for Radiology

I, _____, give the doctors of Turlock Chiropractic Center, my consent to take any and all x-rays needed to better understand my condition. I have been fully informed of the possible risks and safety standards of this office.

I also give my consent for films of my child (children) for the same reasons, if applicable.

Patient Signature: _____ Date: _____

For Ladies only:

To my best knowledge I am not pregnant and know of no contraindications for x-rays at this time.

Patient Signature: _____ Date: _____

Turlock Chiropractic Center

Kevin W. Screen, D.C.
991 E. Monte Vista Avenue, Suite 2
Turlock, CA 95382
(209)632-2288 FAX# (209)250-1788

AUTHORIZATION & ASSIGNMENT OF BENEFITS

- ☐ I authorize the release of any medical or other information necessary to process my insurance claims.
- ☐ I authorize payments to be made directly to Turlock Chiropractic Center & its affiliated doctors.
- ☐ I authorize Turlock Chiropractic Center to act as my agent in helping me obtain payment from my insurance company(s).
- ☐ I understand that I am personally responsible to Turlock Chiropractic Center for any non-covered services, and/or any non-covered private insurance services.
- ☐ I understand that I may revoke this authorization at any time in writing to Turlock Chiropractic Center.
- ☐ I permit a copy of this authorization to be used in place of the original.

Patient Signature: _____Staff Initials: _____Date: _____