



CONFIDENTIAL PATIENT INFORMATION

Date: _____

First: _____ Middle: _____ Last: _____

Street: _____ City: _____ State: _____ Zip: _____

Apt. #: _____ Work Phone: _____ Mobile Phone: _____

Home Phone: _____ Birthdate: _____ Email: _____

SSN: _____

Marital Status: S M D W DP Occupation: _____ Employer: _____

Your MD: _____ Clinic Name: _____ MD's Phone: _____

Name of Insured: _____ Relationship to you: _____

Insured's Date of Birth: _____ Are you here to see Dr. Turnbull Dr. McDonough

1. Most patients are referred to our office by a caring family member, friend or doctor. Who may we thank for referring you? _____ citysearch activa website insurance list google yelp

2. What is the reason for your visit today? proactive injury prevention assessment care for pain/injury science based nutrition/functional medicine internal disorder

Please describe: _____

3. Do you have any other health concerns or conditions? a. _____

b. _____ c. _____ d. _____

4. Research shows that your spine should be checked regularly. How many times have you visited a chiropractor in your lifetime? _____ never

5. Misalignments cause decay and degeneration which can result in grinding or cracking sensations. Do you ever hear noises when you move your head, neck, back or shoulders? no

6. Poor posture leads to poor health and can often be the first sign of a future health crisis. How would you rate your posture? Poor – 1 2 3 4 5 6 7 8 9 10 – Excellent

7. Stress can cause or accelerate physical damage. Please rate your stress level over the past 30 days: Low - 1 2 3 4 5 6 7 8 9 10 - High, Last 90 days: Low - 1 2 3 4 5 6 7 8 9 10 - High

8. Prescription and over-the-counter medications may cause various side effects, hide the severity of health problems and hinder the body's ability to heal. What medicines are you currently taking (prescription and non-prescription)? _____

9. What type of bed do you sleep on? _____ How old is it? _____

Do you wake up well rested? yes no Do you wake up sore or do you roll over frequently due to discomfort? yes no Do you sleep on your side back stomach?

10. Do you take a multi-vitamin fish oil magnesium calcium glucosamine?

other supplements (please list): _____

11. Do you have any problems with your feet knees hips?

12. Do you have any problems with balance coordination stability?

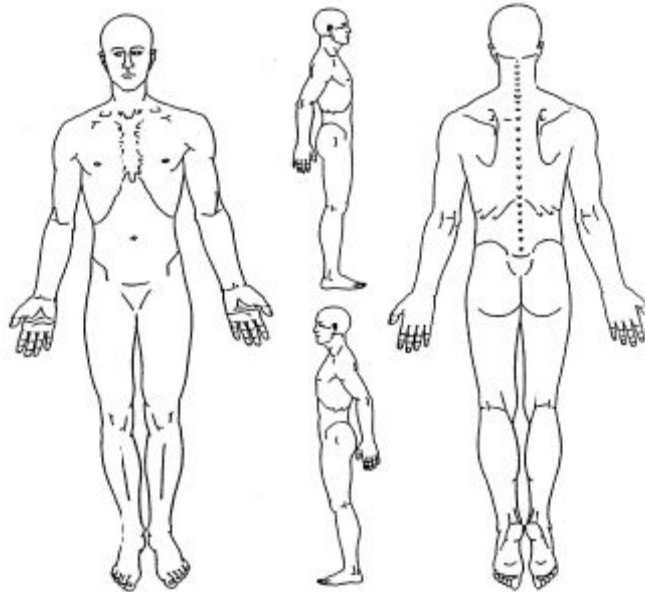
13. Are any of the places you sit uncomfortable? desk chair car seat easy chair airline seat

14. If the doctor feels that he will be able to help you, are you willing to follow his recommendations for care?
 yes no

How long have you had pain or symptoms? _____

On the diagram, please indicate where you are experiencing pain or other symptoms at this moment. Please be as specific as possible and use the following key:

A=Ache, **B**=Burning, **N**=Numbness,
P=Pins & Needles, **S**=Sharp/Stabbing,
O=Other (please describe)



When and how did your problem start?

Is this condition getting better getting worse staying the same unknown

Please rate the severity of your pain: No Pain-- 1-----10 --Excruciating Pain

How often do you have this problem? constant daily frequently intermittently infrequently

Does it interfere with your ability to work sleep recreation daily routine other _____

Does anything make the pain worse? sitting standing walking bending lifting twisting

Does anything make it better? ice heat otc medication other _____



Please list:

Surgeries: _____

Fractures: _____

Medication: _____

Accidents/Injuries: _____

Other Health Conditions (eg. Diabetes, Ulcers, High Blood Pressure, Reflux, Cancer, etc.): _____

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

Patient Signature: _____ Date: _____

Financial Responsibility and Authorization to Release Information

I understand and agree that all services rendered are charged directly to me, and that I am personally responsible for payment upon delivery of services unless prior arrangements are made. All patient co-pays or non-covered percentage fees are to be paid by the patient following each day's services. I understand that should my account fall delinquent, it may be turned over for legal collection and reported to the credit bureau. I agree to pay 1.5% interest per month on any unpaid balance. In addition I agree to pay all court costs, costs of collection at 35% of the unpaid debt and reasonable attorney fees.

We try to serve as many patients as possible each day with minimal waiting time. We reserve your appointment time to achieve this goal. Because of this, we require notice for missed appointments. It is our policy to charge for appointments that are forgotten or willfully missed. We understand that people get sick, cars break down, etc. and we do take that into account. There will be a \$25 charge for no-shows and appointments cancelled with less than 3 hours notice.

If you would like us to file claims to your insurance carrier, statements will be sent to your insurance carrier on a weekly basis. On receipt of benefits, you will be advised of the benefits received, on amounts not paid, or credit balance. You are responsible for any balance due at that time. Credit balance may be refunded or applied toward further care.

I hereby authorize my treating physician(s), to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered; and I hereby release my treating physician(s), of any consequences thereof. I also authorize my insurance and/or attorney to pay by check made out and mailed directly to the clinic of my treating physician(s), any moneys due him, and otherwise payable to me, the same to be deducted from any settlement made on my behalf, for professional services rendered. Further, I agree to pay my treating physician(s) the difference, if any, between the total amount of their charges and the amount paid by the insurance carrier and/or attorney.

Further, I agree that a photocopy or facsimile of this document will be deemed as valid and binding on all parties involved as if the photocopy was the original document I am hereby signing.

If any portion of this contract is deemed unenforceable, the remaining contents remain severable.

Date: _____

Signature of Patient or Legal Guardian (*I acknowledge that I have read and understand the above policy*)

Informed Consent

Some risk is assumed in all treatment modalities, including chiropractic adjustments. Manipulation or adjustment of the human frame carries small risk of injury to weakened or hidden pathology of the vertebral artery in the neck causing death or stroke in reported 1 per 400,000 cases to 1 per 10 million cases. Every effort is made to screen for this and use methods with the lowest risk. Your doctor of chiropractic is the highest licensed professional for specific and safe adjustment of the human frame.

Other complications may rarely include; strain, sprain, dislocation, fracture, disk aggravation, physiotherapy burns, muscle soreness, aches, or other injury. Please ask your doctor of chiropractic if you have any questions.

Subluxation is a misalignment and/or “stuck” joint or tissue, which is found to cause nerve impingement. This interferes with any organ, tissue, or blood vessel supplied by that nerve. Your doctor of chiropractic is trained to look for and find these subluxations, and to correct them with an adjustment. Please do not “pop” or “crack” your joints using a thrust of any kind, nor have an unlicensed person do it for you. Not only can you be hurt, you most likely will not achieve the correction you are looking for. Proper stretching can be very beneficial, and painless popping sounds may be heard and are normal, as long as no forceful thrust or impulse is applied.

After a specific adjustment some people experience the effects of renewed nerve flow and circulation to impinged areas that were restricted by their subluxation. These historically have been changes in; sweating patterns, increased respiratory capacity, faster bowel transit time, increased bowel movement frequency, shift in center of balance perception, sleep pattern changes, shoe fit and clothing measurements, differences in walking (gait), and various organ function changes. These subside quickly as the tissue adjusts itself to the restored nerve flow, but may be temporarily necessary in order for the tissue cells to excrete stored wastes.

Signature: _____ Date: _____

By signing below I consent to the treatment of my minor child.

Signature of Parent of Guardian: _____ Date: _____