ABOUT THE PATIENT

TAHOE **CHIROPRACTIC**

Name _____ Today's Date_____ Birthdate _____ Age_____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____Gender ❑ M ❑ F

Significant Other's Name _____ Kid's Names and Ages _____

Your Employer _____ Type of Work _____

Email Address _____ Have you been to a chiropractor before? □ No □ Yes

Emergency Contact _____ Phone # _____

Are you pregnant? ❑ Yes ❑ No

Are you: ❑ Active Duty Military ❑ A Veteran ❑ A Police Officer ❑ A Firefighter ❑ A First Responder/EMT

I authorize the doctor or his staff to render care as deemed appropriate for me and/or my child.

- I authorize Tahoe Chiropractic Clinic to release and/or request records to or from other providers as may be necessary.
- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- Person responsible for this account if other than the patient?_____
- I understand that after any initial promotional services all care is rendered at usual and customary fees.

_____ _____

Patient / Parent Signature (This represents a long term authorization for all occasions of service) Date

REASON FOR SEEKING CARE

WHAT BRINGS YOU TO OUR OFFICE TODAY?:

Primary issue _____

How long has this been an issue? _____

- Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing
- Is it: ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse
- Rate the pain: ❑ Mild ❑ Moderate ❑ Severe
- Is it: ❑ Worse in the morning ❑ Worse in evening
- Does it radiate? If so, where: _____
- Does it affect: ❑ Sleep ❑ Work ❑ Daily Routine ❑ Sitting ❑ Driving

What makes it better?_____

What makes it worse? _____

What Doctor's have you seen for this? _____

_____

Type of treatment:_____

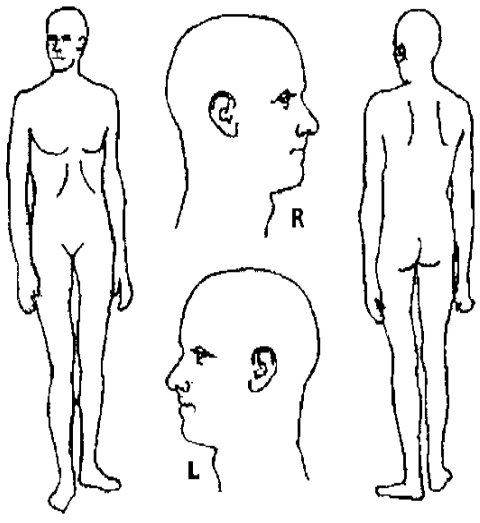
Results: _____

Additional notes/comments: _____

_____

_____

Please mark all areas of concern with an "X" or a circle



Is there anything else you would like to discuss with Dr. Langan?

_____

GENERAL HEALTH HISTORY

Tahoe Chiropractic Clinic, 3121 Harrison Ave, SLT 96150

Patient Name_____ *Mark the conditions that apply to you.*

Past	Present		Past	Present	
❑	❑	Headaches	❑	❑	Urinary Problems
❑	❑	Migraines	❑	❑	Easy Bruising
❑	❑	Shortness of Breath	❑	❑	Tobacco Use
❑	❑	Allergies / Asthma	❑	❑	Dental Problems
❑	❑	Medication Side Effects	❑	❑	Fibromyalgia
❑	❑	Diabetes	❑	❑	Blood Thinner use
❑	❑	Hands or Feet cold	❑	❑	HIV Positive
❑	❑	Muscle aches	❑	❑	Cancer
❑	❑	Trouble Walking	❑	❑	Depression
❑	❑	Leg / Foot Numbness	❑	❑	Alcohol Use
❑	❑	Fainting	❑	❑	___High or ___Low Blood Pressure
❑	❑	Gall Bladder Trouble	❑	❑	Stroke History
❑	❑	Ringing in Ears	❑	❑	High Cholesterol
❑	❑	Ear Problems	❑	❑	TMJ
❑	❑	Sleeping Problems	❑	❑	Digestive Problems
❑	❑	Vision Problems	❑	❑	Pain all Over
❑	❑	Thyroid Problems	❑	❑	Tension / Irritability
❑	❑	Liver Disease	❑	❑	Chest Pains
❑	❑	Kidney Problems	❑	❑	Heart Pacemaker
❑	❑	Light Bothers Eyes	❑	❑	Heart Problems
❑	❑	Other _____			

1. List any medications you are taking:_____

_____

2. Please list all doctors you are currently seeing: _____

_____

3. Has any Doctor or other professional advised you to "Go to a Chiropractor ": ❑ No ❑ Yes, Name_____

_____

_____

PAST HISTORY

4. List any past auto collisions:_____ Was any care received?_____
5. List any past work injuries: _____ Was any care received?_____
6. List any past sport, recreational, or home injuries_____
7. Please describe any past conditions and treatment received: _____

_____

8. Please list any past hospitalizations and surgeries: _____

_____

FAMILY HISTORY

Father's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____

Mother's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____

Is there any other family history you want us to know?_____