TAHOE CHIROPRACTIC CLINIC

Tahoe Chiropractic Clinic

New Patient Paperwork

Name: _____ Date of Birth: _____

Age: _____ Gender: M / F
Height : _____ Weight: _____

Address: _____
City: _____ Zip: _____
Phone number: _____ Email: _____
preferred contact? Call / Text / Email

Emergency Contact? _____ Phone number: _____

Occupation/ Retired from: _____

Marital Status: Married Divorced Widow Single
Children—Names and Ages: _____

Who may we thank for your referral? _____

Insurance Name : _____ ID Number : _____
Guarantor full legal name: _____ Date of birth : _____

What brings you in today? Please list in order of severity.

Complaint When did condition begin?

- _____ _____
- _____ _____
- _____ _____
- _____ _____

Surgeries? _____
Motor Vehicle accidents? Please list dates: _____
Accidents? Date and incidents: _____
Hospitalizations? Reason and date: _____
Medications? _____
Have you had chiropractic care before? Y / N

Patient/ Guardian Signature: _____ Date: _____

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Women

Are you pregnant: Y / N

How far along? _____ weeks Number of pregnancies: _____
Number of births: _____ Currently breast feeding? Y / N Breastfed in past? Y / N
Complications with current or past pregnancies? _____
Last menstrual cycle: _____ Painful menstrual cycle? Y / N
Are you taking birth control? Y / N _____

Please circle any of the following that apply to you now or in the past.

Asthma
Allergies
Difficulty concentrating
Headaches
ADHD/ ADD
Sleep disturbances
Digestive problems
Reflux
Neck pain
Weight loss/ gain
Night pain
Dizzy/ vertigo
Shortness of breath
Cancer
Heart disease
Arthritis
Sinus issues
Fever
Sick more than your peers
Constipation/ IBS
Ear infections
Colic
Fatigue
Numbness/ tingling in hands
Numbness/ tingling in feet
Low back pain
Knee pain
Fever
Loss of balance
Tinnitus
Chest Pain
Stroke
Diabetes
High/ low blood pressure
Seizures
Other: _____

Patient/ Guardian Signature: _____ Date: _____