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:_____

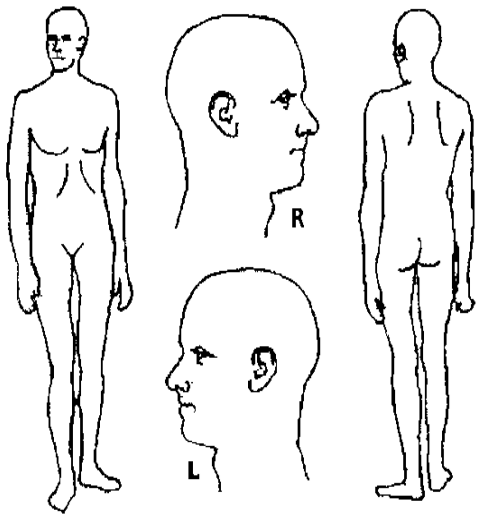
Results: _____

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?_____

Functional Rating Index (FRI)

TAHOE **CHIROPRACTIC**

In order to properly assess your condition we must understand how much your problem(s) has/have affect(ed) your ability to manage everyday activities.

For each item below please circle <u>ONE NUMBER</u> which most closely describes your condition right now.

Name _____ Today's Date_____ Birthdate _____ Age_____

1. Intensity of problem
   0 – None
   1 – Mild
   2 – Moderate
   3 – Severe
   4 – Worst possible

2. Sleeping
   0 – Perfect sleep
   1 – Mildly disturbed sleep
   2 – Moderately disturbed sleep
   3 – Greatly disturbed sleep
   4 – Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)
   0 – No pain, no restrictions
   1 – Mild pain, no restrictions
   2 – Moderate pain, need to go slowly
   3 – Severe pain, need some assistance
   4 – Worst pain, need 100% assistance

4. Travel (store, appointments, vacations, etc.)
   0 – No pain on long trips
   1 – Mild pain on long trips
   2 – Moderate pain on long trips
   3 – Moderate pain on short trips
   4 – Severe pain on short trips

5. Work (washing dishes, sweeping, lawn care, etc.)
   0 – Can do usual work plus unlimited extra work
   1 – Can do usual work but no extra work
   2 – Can do 50% of usual work
   3 – Can do 25% of usual work
   4 – Cannot work

6. Recreation
   0 – Can do all activities
   1 – Can do most activities
   2 – Can do some activities
   3 – Can do a few activities
   4 – Cannot do any activities

7. Frequency of Pain
   0 – No pain
   1 – Occasional pain, 25% of day
   2 – Intermittent pain, 50% of day
   3 – Frequent pain, 75% of day
   4 – Constant pain, 100% of day

8. Lifting (grocery bag, laundry basket, pots, etc.)
   0 – No pain with heavy lifting
   1 – Increased pain with heavy lifting
   2 – Increased pain with moderate lifting
   3 – Increased pain with light lifting
   4 – Increased pain with any lifting

9. Walking (from car to inside, exercise, etc.)
   0 – No pain any distance
   1 – Increased pain after 1 mile
   2 – Increased pain after ½ mile
   3 – Increased pain after ¼ mile
   4 – Increased pain with all walking

10. Standing
    0 – No pain after several hours
    1 – Increased pain after several hours
    2 – Increased pain after 1 hour
    3 – Increased pain after ½ hour
    4 – Increased pain with any standing

For office use: Total Score _____ / 40 * 100 = ☐

INFORMED CONSENT TO TREAT

TAHOE **CHIROPRACTIC**

I hereby request and consent to the performance of chiropractic procedures, including various modes of physiotherapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic indicated below and/or other licensed Doctors of Chiropractic and support staff who now or in the future treat me while employed by, working or associate with or serving as back-up for the Doctors of Chiropractic names below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the Doctor of Chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as in with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then know, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if you wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other options if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intent to consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Name of Patient: _____ DOB: _____

Signature of Patient: _____ Date: _____

If you are a minor, or if you are being represented by another party:

Relationship to Patient: _____

Signature _____ Date: _____

Doctor of Chiropractic Name: Timothy Langan, D.C.

Signature of Doctor of Chiropractic: *Tim Langan, D.C.*