TAHOE CHIROPRACTIC CLINIC
3121 Harrison Ave.
South Lake Tahoe, CA 96150
Phone (530)541-5660
Fax (866)899-6251

DATE: _____/_____/_____

PATIENT NAME: _____

I WOULD PREFER TO BE CALLED: _____ ☐ MALE ☐ FEMALE

HAVE YOU BEEN TO A CHIROPRACTOR BEFORE?: ☐ NO ☐ YES NAME OF DOCTOR: _____

WHO CAN WE THANK FOR REFERRING YOU?: _____

BIRTHDATE: _____ /_____ / _____ AGE: _____ SS#: _____ - _____ - _____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME ADDRESS: ☐ SAME AS MAILING ADDRESS OR _____

CITY: _____ STATE: _____ ZIP: _____

CELL PHONE: _____ HOME PHONE: _____ WORK PHONE: _____

EMAIL ADDRESS: _____ OCCUPATION: _____

STATUS: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED ☐ OTHER

SPOUSE'S NAME: _____ NUMBER OF CHILDREN: _____

EMERGENCY CONTACT NAME/RELATION:_____ PHONE NUMBER: _____

DATE OF LAST: PHYSICAL EXAM: ____/____/_____ X-RAY: ____/____/_____ SPINAL EXAM: ____/____/_____

MRI, CT, OR BONE SCAN: ____/____/_____ ARE YOU PREGNANT?: ☐ NO ☐ YES DUE: _____

ARE YOU TAKING ANY OF THE FOLLOWING MEDICATIONS? ☐ NERVE PILLS ☐ MUSCLE RELAXERS ☐ INSULIN

☐ PAIN KILLERS (INCLUDING ASPIRIN) ☐ BLOOD THINNERS ☐ TRANQUILIZERS ☐ OTHER _____

PLEASE DESCRIBE ANY SURGERIES OR INJURIES: _____

_____

PLACE A MARK ON "YES" OR "NO" TO INDICATE IF YOU'VE HAD ANY OF THE FOLLOWING:

AIDS/HIV	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Pinched Nerve	☐ Yes	☐ No
Allergies	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Polio	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Prostate Issues	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Hernia	☐ Yes	☐ No	Rheum. Arthritis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Herniated Disk	☐ Yes	☐ No	Sinus Condition	☐ Yes	☐ No
Backaches	☐ Yes	☐ No	Migraine Headaches	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Other Headaches	☐ Yes	☐ No	Thyroid Issues	☐ Yes	☐ No
Concussion	☐ Yes	☐ No	Multiple Sclerosis	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Muscular Dystrophy	☐ Yes	☐ No	Tumors	☐ Yes	☐ No
Digestive Disorder	☐ Yes	☐ No	Neuritis	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Dizziness/Vertigo	☐ Yes	☐ No	Numbness	☐ Yes	☐ No	Other		
Emphysema	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	_____		
Epilepsy	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	_____		
Fractures	☐ Yes	☐ No	Parkinson's Disease	☐ Yes	☐ No			

NUMBER OF DAYS A WEEK YOU EXERCISE: _____ TYPE OF ACTIVITY: _____

TYPE OF WORK ACTIVITY: ☐ SITTING ☐ STANDING ☐ LIGHT LABOR ☐ HEAVY LABOR

SMOKER?: ☐ NO ☐ YES PACKS/DAY: _____ DO YOU DRINK ALCOHOL?: ☐ NO ☐ YES DRINKS/WEEK: _____

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WHAT IS YOUR MAJOR COMPLAINT OR CONCERN?: _____

_____

WHEN DID THE SYMPTOMS APPEAR?: _____

ARE THE SYMPTOMS GETTING: ☐ WORSE ☐ BETTER

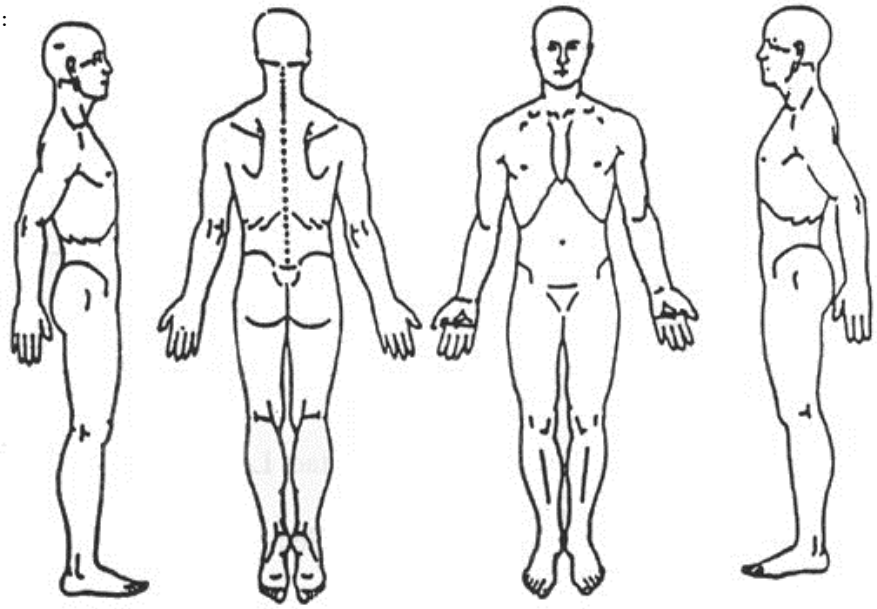
WHAT TREATMENT HAVE YOU ALREADY RECEIVED FOR THIS CONDITION?: (EX. MEDICATION, CHIROPRACTIC, SURGERY):

_____

RATE THE SEVERITY OF YOUR PAIN **TODAY** ON A SCALE FROM 1 (LEAST PAIN) TO 10 (MOST PAIN): _____

TYPE OF PAIN (CIRCLE): SHARP (S) / DULL (D) / THROBBING (TH) / ACHING (A) / SHOOTING (SH) / BURNING (B) / NUMBNESS (N) / TINGLING (T) / STIFFNESS (ST) / OTHER (O): _____

USE THE INDICATOR FROM ABOVE TO MARK THE AREAS OF DISCOMFORT (FOR EXAMPLE, FOR AN ACHING KNEE PLACE "A" OVER KNEE IN PICTURE):



HOW OFTEN DO YOU HAVE THIS PAIN?:

☐ CONSTANT (+75%) ☐ FREQUENT (50-75%) ☐ OCCASIONAL (25-50%) ☐ INTERMIT (<25%)

DOES IT INTERFERE WITH: ☐ WORK ☐ SLEEP ☐ DAILY ROUTINE ☐ RECREATION

ARE THESE ACTIVITIES/MOVEMENTS PAINFUL TO PERFORM?:

☐ SITTING ☐ STANDING ☐ EXERCISING ☐ WALKING ☐ BENDING ☐ LYING DOWN

OTHER COMMENTS OR CONCERNS REGARDING YOU CONDITION: _____

_____

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process/secure insurance claims/benefits, and I assign all applicable insurance benefits directly to the provider. I understand the above information and guarantee this form was completed to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

PATIENT SIGNATURE: _____ DATE: _____/_____/_____

GUARDIAN SIGNATURE: _____ DATE: _____/_____/_____

IF PATIENT UNDER 18