NEW PATIENT INTAKE FORM

Aspire Chiropractic | 6248 Davis Blvd Ste 300 NRH,TX 76180

Name:_____ _____ Occupation: _____

DOB:_____ Age: _____Sex: ❑ Male ❑ Female Employer:_____

Marital Status: ❑ Single ❑ Married ❑ Other Name/Age of Kids:_____

Phone: (_____) _____ - _____ (Cell) _____

(_____) _____ - _____ (Home) Spouse/Partner Name: _____

Address: _____ In case of emergency, contact: _____

_____ Phone: (_____) _____ - _____

Email: _____ Relationship: _____

Name of Medical Dr(s) _____ Have you been to a chiropractor before? ❑ Yes ❑No

Who may we thank for referring you to our office? _____

- I authorize the doctor or his staff to render care as deemed appropriate for me and / or my child.
- I authorize Aspire Chiropractic 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.
- For my balance my preferred payment method is: ❑ Cash ❑ Check ❑ Credit Card ❑ Car/Work Ins.

_____ _____

Patient / Parent Signature Date

REASON FOR SEEKING CARE

1. _____ **How Long Has This Been An Issue?** _____

Is It: ❑ Dull ❑ Sharp ❑ Achy ❑ Numb/Tingle ❑ Stabbing ❑Constant ❑ Occasional
❑Staying The Same ❑ Worsening ❑ Worse In The Morning ❑ Worse In The Evening

2. _____ **How Long Has This Been An Issue?** _____

Is It: ❑ Dull ❑ Sharp ❑ Achy ❑ Numb/Tingle ❑ Stabbing ❑Constant ❑ Occasional
❑Staying The Same ❑ Worsening ❑ Worse In The Morning ❑ Worse In The Evening

3. _____ **How Long Has This Been An Issue?** _____

Is It: ❑ Dull ❑ Sharp ❑ Achy ❑ Numb/Tingle ❑ Stabbing ❑Constant ❑ Occasional
❑Staying The Same ❑ Worsening ❑ Worse In The Morning ❑ Worse In The Evening

What is your **current** (○) and **worst** (□) pain level?

1 2 3 4 5 6 7 8 9 10 (Circle one/ Square one)

Have you seen anyone for care❑ No ❑ Yes Who _____

Treatment given ❑ No ❑ Yes _____

Effective ❑ No ❑ Yes _____

Do any of these conditions affect: ❑ Sleep ❑ Driving ❑ Standing
❑ Work ❑ Sitting ❑ Daily Routine

❑ Other: _____

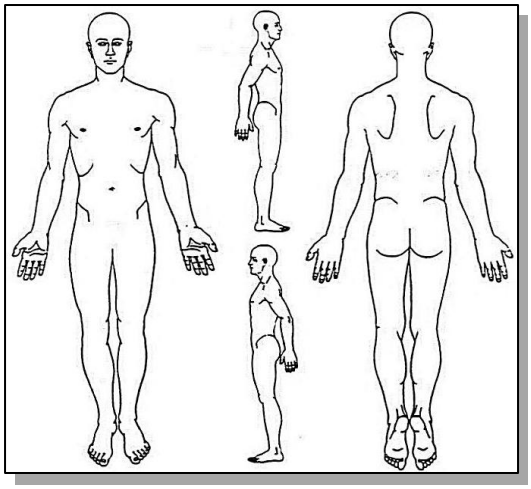
Does anything make it better? _____

Does anything make it worse? _____

NOTES: _____

_____

Please mark all areas of concern



Are you Pregnant? ❑ No ❑ Yes

FUNCTIONAL RATING INDEX

For use with Neck and/or Back Problems

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item, please **circle** the number which most closely describes your condition right now.

1) Pain Intensity

0	1	2	3	4
No pain	Mild Pain	Moderate Pain	Severe Pain	Worst Pain

2) Sleeping

0	1	2	3	4
Perfect Sleep	Mildly Disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3) personal care (washing, dressing, etc)

0	1	2	3	4
No pin; no restriction	Mild pain, no restrictions	Moderate pain, need to go slowly	Moderate pain. Need some assistance	Severe pain. Need 100% assistance

4) Travel (driving, etc)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5) Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work, no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6) Recreations

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7) Frequency of Pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermitten t pain: 50% of the day	Frequent pain: 75% of the day	Constant pain: 100% of the day

8) Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9) Walking

0	1	2	3	4
No pain, any distance	Increased pain after 1 mile	Increased pain after ½ mile	Increased pain after ¼ mile	Increased pain with all walking

10) Standing

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

HEALTH PROFILE

What are your health goals? _____

Is your current condition the result of: ❑ Auto Accident ❑ Work Injury Date of Injury: _____

May we share information w/ your physician regarding our findings, conclusions and recommendations? ❑ Yes ❑ No

Medication	Reason for Taking	Frequency	Start Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

GENERAL HEALTH HISTORY

Past	Present		Past	Present		Past	Present	
❑	❑	Headaches	❑	❑	Digestive Problems	❑	❑	Urinary Problems
❑	❑	Migraines	❑	❑	Pain All Over	❑	❑	Easy Bruising
❑	❑	Shortness Of Breath	❑	❑	Tension / Irritability	❑	❑	Tobacco Use
❑	❑	Allergies / Asthma	❑	❑	Chest Pains	❑	❑	Dental Problems
❑	❑	Medication Side Effects	❑	❑	Heart Pacemaker	❑	❑	Fibromyalgia
❑	❑	Diabetes	❑	❑	Heart Problems	❑	❑	Blood Thinner Use
❑	❑	Cold Hands Or Feet	❑	❑	Sleeping Problems	❑	❑	TMJ
❑	❑	Muscle Aches	❑	❑	Vision Problems	❑	❑	Cancer
❑	❑	Trouble Walking	❑	❑	Thyroid Problems	❑	❑	Depression
❑	❑	Leg / Foot Numbness	❑	❑	Liver Disease	❑	❑	Alcohol Use
❑	❑	Fainting	❑	❑	Kidney Problems	❑	❑	___High ___ Low Blood Pressure
❑	❑	Gall Balder Trouble	❑	❑	Sensitive To Light	❑	❑	Stroke History
❑	❑	Ringing In Ears	❑	❑	Ear Problems	❑	❑	High Cholesterol

❑ ❑ Other _____

Has Any Doctor Or Other Professional Advised You To "Go To A Chiropractor"? ❑ Yes ❑ No

Name _____

PAST HISTORY

Any past auto accidents (date) _____ Was any care received ❑ No ❑ Yes _____

Any past work injuries (date) _____ Was any care received ❑ No ❑ Yes _____

Any past sport injuries (date) _____ Was any care received ❑ No ❑ Yes _____

Any past conditions and/or treatment received _____

_____

Any past hospitalizations or surgeries received _____

_____

FAMILY HISTORY

Fathers Side ❑ Heart disease ❑ Cancer ❑ Diabetes ❑ Arthritis ❑ Other: _____

Mothers Side ❑ Heart disease ❑ Cancer ❑ Diabetes ❑ Arthritis ❑ Other: _____

Any other pertinent family history? _____

Please list the **cause of death** and **age** of any immediate family members (Parents, Siblings, Children)

_____