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?** _________________

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What is your **current** (O) 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? ________________________________

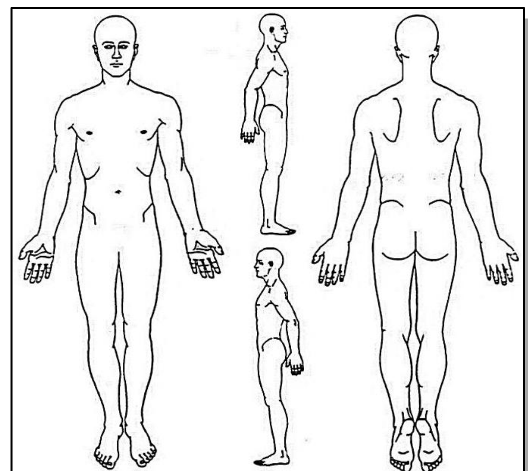
Does anything make it worse? ________________________________

NOTES:____

____

Are you Pregnant? ❑ No ❑ Yes

Please mark all areas of concern



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)

____

COLLISION INFORMATION

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

# of people in vehicle: _____ Date of collision:___________ AM / PM Was the road: ❑ Dry ❑ Wet ❑ Snowy ❑ Icy

Where did the collision occur: Street:_________________________ City:___________________________ State:______

How were you struck (Front, Back, Side-swipe, etc)?____

Describe what happened:____

____

____

____

____

____

____

CRASH DETAILS

❑ Yes	❑ No	If driving, were both hands on the wheel at impact?	❑ Yes	❑ No	Did you hit the dash, steering wheel or window?
❑ Yes	❑ No	If passenger, did your hands brace yourself?	❑ Yes	❑ No	Did you know you were going to be hit?
			❑ Yes	❑ No	Did you brace yourself with hands or feet?
❑ Yes	❑ No	Did you have your seat belt and shoulder strap on?	❑ Yes	❑ No	If driving, was your foot on the brake at impact?
❑ Yes	❑ No	Was your seat up at the time of impact?	❑ Yes	❑ No	Was your head turned at impact?
❑ Yes	❑ No	Where you wearing a bulky coat or slippery pants?	❑ Yes	❑ No	Were you leaning forward?
			❑ Yes	❑ No	Did your glasses fly-off at impact?
❑ Yes	❑ No	Did the seat belt engage?	❑ Yes	❑ No	Was your body turned at the moment of impact?
❑ Yes	❑ No	Did the airbag engage?			
❑ Yes	❑ No	Any damage on your vehicle, the vehicle that hit you, or an object that was hit?	❑ Yes	❑ No	Did you get hit into another car, tree, railing, etc?

What part of the vehicle was hit? ____

1. What make and model of vehicle were you in?_________________ The other vehicle?_________________
2. Where were you seated in the car?___________________________
3. What kind of seat were you in? __ Bucket __ Bench __ Fabric __ Leather/Vinyl
4. Did the car have headrests? ❑ Yes ❑ No
5. Did you hit your head on the headrest? ❑ Yes ❑ No On the back window if in a small truck? ❑ Yes ❑ No
6. Was the headrest positioned: __ below __ level with __ above the center of your head
7. Approximate speed of your vehicle? ________ Approximate speed of other vehicle? _______
8. Did your head hurt after the collision? ❑ Yes ❑ No Did your TMJ/jaw hurt after the collision? ❑ Yes ❑ No
9. How soon after the collision did you notice any pain? ____
10. Did the crash affect: ❑ dizziness ❑ memory ❑ concentration ❑ headaches ❑ balance ❑ nightmares ❑ breathing ❑ fatigue ❑ irritability ❑ ability to read ❑ ability to listen ❑ appetite ❑ nausea ❑ vision
11. How did you feel:
    Immediately after________________ Later the same day________________ The next day________________
12. Is there anything else you want us to know?____

____

CRASH DETAILS (con't)

List all providers seen since injury occurred:

1. Clinic/Doctor/Hospital Name: ______________________________ City: ______________
2. Clinic/Doctor/Hospital Name: ______________________________ City: ______________
3. Clinic/Doctor/Hospital Name: ______________________________ City: ______________

❑ Yes ❑ No Do you have pictures of your vehicle? Where is it being repaired? ______________________

❑ Yes ❑ No Do you have a copy of the police report?

Name of your Attorney if you have one: ______________________________

Name of Your Car Insurance Co.______________________ Your Health Ins. Co. ______________________

Name of the Other Divers car Insurance if Applicable ______________________________

Have you tried anything at home to help the symptoms? ______________________________

Have you missed work due to the injury (describe)? ______________________________

Have you noticed any restrictions in your normal routine or work as a result of the current injury?______________

____

Have you returned to work ❑ Yes ❑ No Are you able to work normal hours/tasks? ❑ Yes ❑ No

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. 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 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	Intermittent 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

Name: ______________________ ID#: ____________ Group #: ______________

Signature: ______________________ Date: ____________ Score: ______________