ASPIRE
GET BACK TO LIVING

New Patient Information

Name_____ Age_____ Sex_____ Date_____

Address_____ City, State_____ Zip_____

Phone # (Home)_____(Cell)_____(Work)_____

E-Mail_____ Birthdate_____ Social Security #_____

Primary Doctor_____ Phone Number_____

Referring Doctor_____ Phone Number_____

Employer & Address_____

Work Status ____ Employed ___Off Work _____Unemployed ____ Retired ____Disabled

Emergency Contact Name & Phone #_____

Insurance Carrier(s)_____ Policy Holder: (Circle one) Self Spouse Parent

(If Not Yourself) Name: _____ Sex: _____ DOB: _____

Is your condition related to auto accident or work injury? _____Date of Injury_____

****We will send you a confirmation text prior to all future visits. ***

Cell Phone Carrier _____

Please provide the front desk with your driver's license &insurance card to be photocopied for your medical records.

Welcome to Aspire. This Facility is required by law to abide by the terms of this Health Care Privacy Consent as well as other applicable federal & state laws governing privacy practices in health care. Photocopy of this consent is available to you upon request. The term Facility refers to this office or clinic. The term Provider refers to the licensed professionals of this Facility. Our Facility, Providers & staff are committed to your present, future and past physical or mental health or condition and the care and treatment you receive from our facility. At the front desk of this office is a HIPAA Privacy Notice that describes how medical information about you may be used and disclosed and how you can obtain access to this information. You are welcome to read this notice and direct questions, misunderstandings or concerns to the Compliance Officer of this facility. Our Facility may use & disclose your PHI for health care delivery purposes only. Your PHI maybe used and/or disclosed without written authorization by the providers and staff of this facility for your and treatment; paying health care bills; and to support the operations of this practice. Your providers and the staff will take reasonable measures to maintain the confidentiality of your PHI. Our facility is committed to providing all patients regardless of race, color, national origin, age, sex, disability or religious or political beliefs quality health care services delivered with dignity and concern, we will strive to help restore or improve your health but there are no guarantees or promises of improvement or complete recovery.

By my signature below I acknowledge that I have read or have had read to me and have received a photocopy upon my request of this document including the Health Care Privacy Notice. I am disclosing pertinent, truthful and comprehensive information on these forms and to my provider(s).

Name:_____ Date:_____

ASPIRE
GET BACK TO LIVING

Medical History

1. Briefly describe your chief complaint/symptoms:_____

2. When did it start? _____ Was it caused by injury/trauma? ___YES ___ NO

3. How are your symptoms changing? ___ Getting Better ___ Not Changing ___ Getting Worse

4. How would you rate your pain right now on a scale of 1 = minimal pain; 10 = excruciating pain: _____

5. What activites make your symptoms worse? (Circle all that apply):

Standing Sitting Stairs Lying Bending Twisting walking Looking Up Other:_____

6. What makes your symptoms better? (Circle all that apply):

Standing	Twisting	Motrin	Ice	Stretching	Hyalgan
Sitting	Walking	Advil	Heat	Exercise	Physical Therapy
Lying	Tylenol	Aleve	Biofreeze	Massage	Other:_____
Bending	Ibuprofen	Narcotics	Icy Hot	Cortisone	

7. Is your pain constant or does it come and go? ____ Constant ____Comes and goes

8. Does the pain radiate? ___ Yes ___ No If Yes, where does the pain radiate to? _____

9. Do you feel numbness/tingling? ___ No ___Numbness ___Tingling

10. If yes, where is the numbness/tingling? _____

11. Is your pain affected by weather? ___ Yes ___No

12. Describe your pain? (Circle all that apply):

Aching	Deep	Sharp	Stabbing	Throbbing
Burning	Deep	Stiff	Tingling	Random
Dull	Numbness	Shooting	Weakness	Other:_____

13. What methods have you tried for your symptoms? (Circle all that apply):

Chiropractic	Epidurals	Brace/Orthotics
Physical Therapy	Steroid Injections	Surgery
TENS unit	Hyalgan Injections	Other: _____

14. Any falls in the last year? ___Yes ___No Were you injured? _____

15. Do you have an Advanced Directive or Durable Power of Attorney? ___Yes ___No

16. Have you ever received the pneumococcal vaccine? ___Yes ___No

17. Do you currently smoke cigarettes? ___Yes ___No

If yes, would you like info on quitting? ___Yes ___No

Signature:_____ Date:_____

Medical History

18. Do you drink alcohol? ___Yes ___No If yes, how often have you had a drink containing alcohol in the last year? (Circle one): Never Monthly or less 2-4 times/month 2-3 times/week 4+ times/week

19. In the last year, how many drinks containing alcohol did you have on a typical day when drinking? (Circle one): I do not drink alcohol 1-2 drinks 3-4 drinks 5-6 drinks 7-9 drinks 10+ drinks

20. How often did you have 5 or more drinks on ONE occasion in the last year? (Circle one):

Never Less than monthly Monthly Weekly Daily or almost daily

21. Do you have difficulty sleeping due to your pain? ___ Yes ___ No

22. Is there a time of day your pain is worse? ___ No ___Yes If yes, When? _____

23. Do you have a history of a GI bleed? ___ Yes ___ No

24. Have you had or do you now have ulcers in your stomach? ___ Yes ___ No

25. List all surgeries you have had: _____

_____

26. List all medications and dosages **OR** provide a list:

_____

_____

27. List all DRUG allergies?

_____

28. Are you currently pregnant? ___N/A ___Yes ___No

29. Do you have any difficulty consuming chicken or egg products? ___Yes ___No

30. What is your height and weight? _____

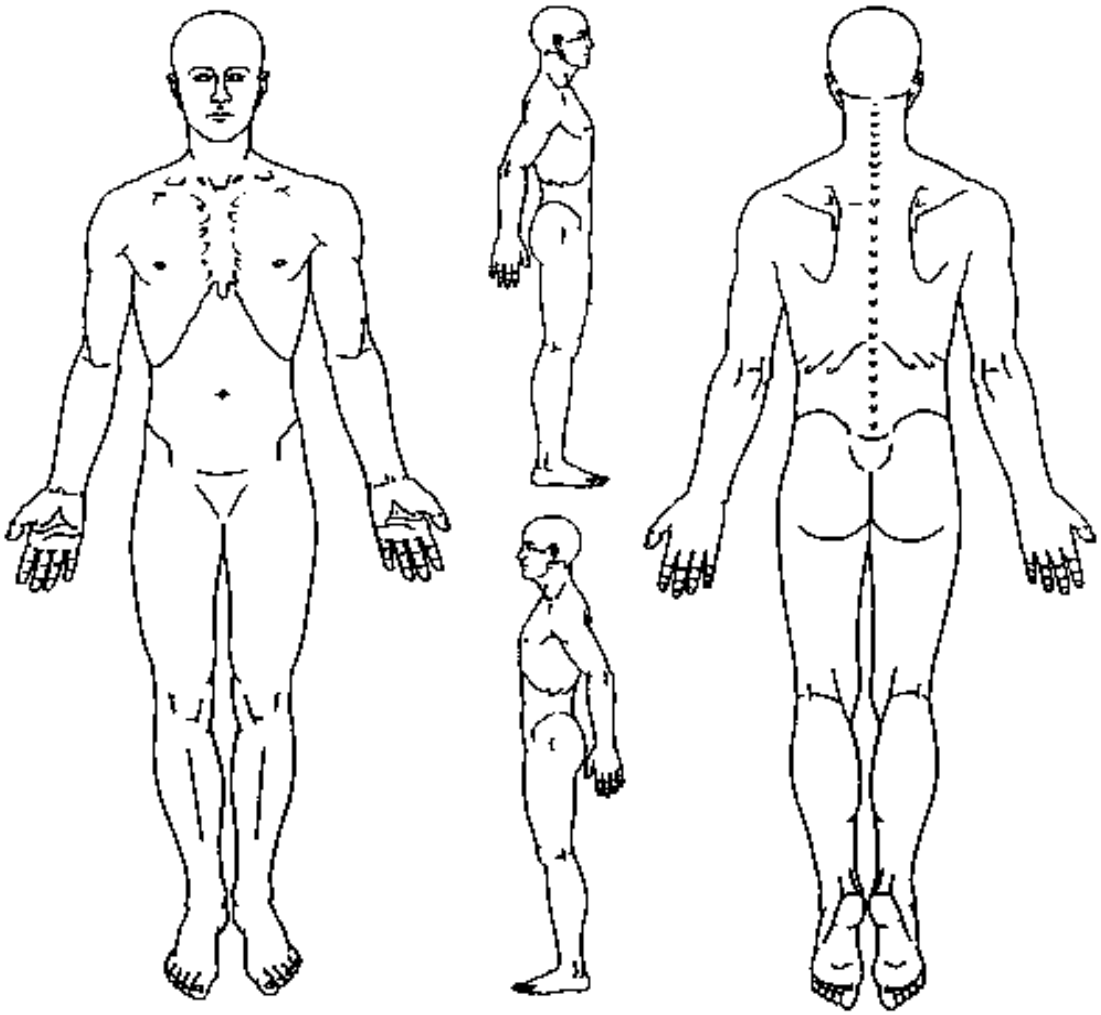
31. Do you have any hardware in your body? ___ Yes ___No If yes, where?:_____

32. <u>CHECK All the Items You Have Been Diagnosed with or Treated for in the Past:</u>

___ Arthrtis (OA or RA)	___Defibrillator	___Pacemaker	___ Neurostimulator
___Asthma	___COPD/Lung Issue	___Neck Pain	___Back Pain
___High Blood Pressure	___Stroke/TIA	___Fibromyalgia	___Diabetes
___Headaches	___Broken Bones	___MS	___Osteoporosis
___Cancer	___Parkinson's	___GERD/Reflux	
___Infectious Dz	___Heart Issues	___Abdominal Aneurism	

Signature:_____ Date:_____

Medical History



A = ACHE	**B**=BURNING	**W**=WEAKNESS
S = SHARP	**N** = NUMBNESS	**T**=TINGLING

Signature:_____ Date:_____

ASPIRE
GET BACK TO LIVING

Medical History

D=DULL **O**=OTHER

For Medicare patients, only (Please circle yes or no to each question below)

Y N Are you currently or have you been treated by a physical, occupational, or speech therapist this calendar year?

Y N Is your illness due to work related accident/condition and is it being covered by work comp?

Y N Is your illness or injury covered under automobile insurance, no fault insurance, medical payments coverage, personal injury insurance, liability insurance, or a medical "set aside" account from a legal settlement?

Y N Are you being treated by for an injury/illness for which another party could be liable?

Insurance Benefits- Credit Policies- Payment Terms & Conditions

As a courtesy, the Facility will obtain a verification of applicable insurance benefits as they are quoted to us. Our Facility & staff are not responsible for what a third-party payer and/or representative may tell us. Any contractual, written, verbal or other obligations or arrangements between you and an attorney, insurance company, liable or third party payer are between you and said person.

1. Our Facility will file insurance claims for you including Medicare. Medigap, and other health insurance companies.
2. Patients are fully responsible for all money owed this office and such payment is not contingent on any settlement. claim, judgment, or verdict by which they may eventually recover said fee and it is also regardless of any attorney liens or pending settlement(s). Assignee is fully responsible for all money owed to this Facility for all treatment. Products & services rendered to the patient or minor shown below.
3. Returned checks, debit & credit charges made payable to this Facility for insufficient funds, stop payments or other reasons of non-payment will be assessed a $30.00 charge
4. If you miss a appointment and not give an advanced notice of 24 hours, you will be charged a $25.00 missed appointment fee.

Informed Consent

I understand that this Facility, its providers & staff are accepting my case based on examination findings & believe the outlined treatment should produce change and/or improvement. However, as with any examination, health history, or diagnostic test findings, a guarantee of improvement or complete recovery cannot be made and it is even possible that no change will occur. I further understand that in the practice of physical therapy, chiropractic, & medicine there are some risks including but not limited to fractures, disk injuries, dislocations, sprains-strains and/or other injuries or side effects that cannot be pre-determined. I do expect the provider to be able to anticipate and explain all risk and/or complication, and I wish to rely on the provider to exercise judgment during the procedure(s) which the provider feels at the time is in my best interest. In addition, because psychosocial, spiritual, and cultural values affect a patient's response to care, patients can express and follow spiritual beliefs and cultural practices that do not harm others or interfere with the planned course of treatment. Patients have the right to refuse treatment, but must be aware of the probable consequences of refusing treatment and/or failing to cooperate with the prescribed treatment. Should you refuse and/or fail to comply with prescribed treatment your

Signature:_____ Date:_____

provider will discuss specific with you. Therefore, I give my full consent to the provider of this Facility to render treatment on me or the minor for whom I am legally responsible.

Notes:

Signature:_____ Date:_____