ASCEND
CHIROPRACTIC

Date: _____

Patient # _____

New Patient Intake Form

_____

First Name | Last Name | Age | Date of Birth

_____

Sex | Height | Weight

_____

Occupation | Marital Status | # of Children

_____

Street Address | City | State | Zip Code

_____

Email Address | Phone Number

_____

Emergency Contact Name | Relation to You | Emergency Contact Phone #

_____

Primary Care Physician | Date of Last Doctor Visit

Reason for Most Recent Doctor Visit: _____

Please list any other health professionals you're receiving care from and their specialty:

_____

How did you hear about **Ascend Chiropractic**?: _____

Please list what health condition(s) bring you into **Ascend Chiropractic:**

_____

Have you received care for this problem before?: ☐ **YES** ☐ **NO**

If yes, please explain:

_____

When did the condition first begin?: _____

How did the problem start? ☐ **SUDDENLY** ☐ **GRADUALLY** ☐ **POST-INJURY**

Is this condition: ☐ **INTERMITTENT** ☐ **CONSTANT**

Is this condition: ☐ **GETTING WORSE** ☐ **IMPROVING** ☐ **STAYING THE SAME**

Rate your average level of pain: **1 2 3 4 5 6 7 8 9 10**

What makes the problem **better**?:

_____

What makes the problem **worse**?:

_____

Does this condition limit your ability to perform daily tasks, activities, work, etc.? Explain:

_____

Have you ever had any significant falls, injuries, or surgeries as an adult? If yes, please explain:

_____

Did you have any notable childhood injuries?:

_____

Did you play youth or college sports?:

_____

Were you involved in any past auto accidents? If yes, please explain:

_____

List any problems with flexibility (i.e. putting on shoes socks, etc.):

_____

How many hours per day do you typically spend in the car?: _____

How many hours per day do you typically spend sitting at a desk?: _____

Please rate your STRESS for each of the following categories:
(0 being none, 3 being moderate, and 5 being high)

Home:	**0**	**1**	**2**	**3**	**4**	**5**	Life:	**0**	**1**	**2**	**3**	**4**	**5**
Work:	**0**	**1**	**2**	**3**	**4**	**5**	Other:	**0**	**1**	**2**	**3**	**4**	**5**

Job description (what activities do you perform at work?):

_____

How regularly do you exercise?: ☐ **DAILY (** _____ x per day) ☐ **WEEKLY (** _____ x per week)

☐ **OCCASIONALLY** ☐ **NEVER**

What type of exercise do you do?:

_____

How many hours of sleep do you get each night? (on average): _____

On a scale of 1-10, how would you grade your overall health and function? (1=poor, 10=excellent): ___

Are you pregnant?: ☐ **YES** ☐ **NO**

Are you breastfeeding?: ☐ **YES** ☐ **NO**

Are you currently on birth control?: ☐ **YES** ☐ **NO**

Do you smoke?: ☐ **YES** (___ packs per week) ☐ **NO**

Do you drink alcohol?: ☐ **YES** (___ drinks per week) ☐ **NO**

Do you drink soda?: ☐ **YES** (___ cans per week) ☐ **NO**

Do you drink coffee?: ☐ **YES** (___ cups per week) ☐ **NO**

How many ounces of water do you drink daily? _____

Please list any drugs/medication/vitamins/herbs/nutritional supplements you are currently taking:

_____

Have you ever visited a chiropractor before?: ☐ **YES** ☐ **NO**

If you have seen a chiropractor before, please answer the following questions

What is the name of that chiropractor?: _____

When did you last see them?: _____

What would you like to gain from chiropractic care?:

_____

What are your top 3 health goals?:

1.) _____

2.) _____

3.) _____

Please check all health issues **YOU** have experienced in the last **6 months**, even if they do not seem to relate to your current problem(s):

☐ Anemia ☐ Diabetes ☐ Irritability ☐ Shoulder Pain
☐ Asthma ☐ Diarrhea ☐ Depression ☐ Stomach Pain
☐ Cancer ☐ Hip Pain ☐ Knee Pain ☐ Menstrual Pain
☐ Allergies ☐ Fatigue ☐ Fainting ☐ Low Back Pain
☐ Heartburn ☐ Sore Throat ☐ Dizziness ☐ Constipation
☐ Stroke ☐ Ulcers ☐ Mood Swings ☐ Appendicitis
☐ Indigestion/Gas ☐ Tension/Anxiety ☐ Loss of Memory
☐ Loss of Balance ☐ Irregular Cycle ☐ Loss of Taste
☐ Loss of Smell ☐ Swollen Joints ☐ Erectile Dysfunction
☐ Frequent Urination ☐ Shortness of Breath ☐ Sleeping Problems
☐ Upper Back Pain ☐ Ringing in Ears ☐ Numbness in Fingers
☐ Sinus Congestion ☐ Headache/Migraine ☐ High Blood Pressure
☐ Poor Concentration ☐ Neck Pain/Stiffness ☐ Pins/Needles in Legs/Feet
☐ Epilepsy/Seizure ☐ Hyper/Hypothyroidism ☐ Pins/Needles in Arms/Hands ☐ Alcoholism ☐ Arteriosclerosis ☐ Multiple Sclerosis
☐ Scarlet Fever ☐ Osteoporosis ☐ Pneumonia
☐ Heart Disease ☐ Tuberculosis ☐ Emphysema
☐ Typhoid Fever ☐ AIDS ☐ Gout
☐ Polio ☐ Measles ☐ Malaria
☐ Mumps

Please check any conditions that **YOUR FAMILY members** have had in the past or currently have:

☐ AIDS	☐ Gout	☐ Polio	☐ Measles	☐ Malaria
☐ Anemia	☐ Stroke	☐ Mumps	☐ Diabetes	☐ Cancer
☐ Alcoholism		☐ Scarlet Fever		☐ Osteoporosis
☐ Epilepsy/Seizure		☐ Pneumonia		☐ Heart Disease
☐ Appendicitis		☐ Hyper/Hypothyroidism		☐ Tuberculosis
☐ Arteriosclerosis		☐ Multiple Sclerosis		
☐ Emphysema		☐ Typhoid Fever		

Terms of Acceptance: When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. We have found that if each patient understands the meaning and goal of chiropractic care, they respond much better to their care. This is why here at Ascend Chiropractic, patient education is a priority. Please understand that chiropractic has only one goal and it is important that each patient understands both the objective and the methods that will be used to attain it. This will prevent any confusion or disappointment and help you reach your goals.

Adjustment: An adjustment is the specific application of force to facilitate the body's correction of a subluxation. Our chiropractic method of correction is by specific adjustments of the spine. As with any form of health care, in very rare instances, chiropractic care may pose certain risks. Sprain, strain, or general aggravation of an inflammatory condition may result from certain chiropractic maneuvers. According to research, the chance of this is approximately 1 in 3.3 million. As with many health related procedures, a patient may have soreness during the initial phase of care.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which may cause alteration in the nerve function and interference to the transmission of mental impulses from the brain through the nervous system to the rest of the body. This can result in a lessening of the body's innate ability to express its maximum health potential resulting in a state of dis-ease. We do not offer to diagnose or treat any condition other than vertebral subluxation nor do we offer advice regarding treatment prescribed by others. However, if during the course of a chiropractic spinal examination we encounter an unusual finding, we will advise and refer you to a health care professional that specializes in that area of health care.

Office Policies

For best results, visit frequency should be kept according to your suggested treatment plan.
It is best for missed appointments to be made up within 48 hours for you to see optimum results.

Please call if you are going to be late.

If three or more appointments are missed without any call or notification, we will consider your case self dismissed. Payment in full is to be expected after each treatment, unless other arrangements have been made. All charges that insurance does not cover are ultimately your responsibility.

HIPAA Privacy Information

By signing below I agree that I have had the opportunity to read the office HIPAA privacy regulations and patient's rights and have been offered a copy of them for my records.

Patient Signature: _____ Date: _____

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Patient Signature: _____ Date: _____

By signing this form, I authorize the release of all information to my insurance companies. I authorize my insurance company to remit payment directly to the doctor. I hereby give my permission to receive chiropractic care performed by Dr. Krantz and staff. I understand that regardless of any insurance coverage, I am personally responsible for my bill. I also understand any nutritional program is not intended as primary therapy for any disease. Supplements are provided solely to support good nutrition with the intent of supporting the physiological and biochemical processes of the human body. We do not offer to diagnose, treat, cure, or prevent any disease or condition other than neuromusculoskeletal conditions. We do expect payment at the time of service unless otherwise specified.