NEW PATIENT INTAKE

Name:_____ Today's Date:_____

Address:_____City_____State____Zip_____

Cell Phone ( )_____Work ( )_____

We use text messaging for appointment reminders. Who is your cell phone company?_____

Email Address:_____

Date of Birth:_____ Age: _____Social Security #_____

Occupation: _____ Employer: _____

Work address: :_____City_____State____Zip_____

Single_____ Married_____ Spouse's Name_____

Health Insurance? Yes No If yes, _____

Have you seen a Chiropractor before? Yes No If yes, when?_____

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

YOUR HEALTH SUMMARY

Please ☑ check all symptoms you have ever had, even if they do not seem related to your current problem.

- ☐ Headaches
- ☐ Neck Pain
- ☐ Dizziness
- ☐ Sleeping problems
- ☐ Pins and needles in arms
- ☐ Numbness in fingers
- ☐ Fatigue
- ☐ Cold Sweats
- ☐ Mood Swings
- ☐ Loss of smell
- ☐ Buzzing in ears
- ☐ Depression
- ☐ Neck Stiff
- ☐ Lights Bother Eyes
- ☐ Fainting
- ☐ Loss of taste
- ☐ Irritability
- ☐ Cold Hands
- ☐ Fever
- ☐ Loss of balance
- ☐ Nervousness
- ☐ Tension
- ☐ Hot Flashes
- ☐ Mid back pain
- ☐ Stomach upset
- ☐ Heartburn
- ☐ Ulcers
- ☐ Asthma
- ☐ Low Back Pain
- ☐ Pain down legs
- ☐ Pins and Needles in legs
- ☐ Constipation
- ☐ Numbness in toes
- ☐ Menstrual Pain
- ☐ Problem urinating
- ☐ Menstrual Irregularity
- ☐ Cold Feet

List any medications you are taking _____

This office conforms to the current HIPAA guidelines. You may request a copy of our HIPAA policy at the front desk. Please initial to indicate you have been made aware of its availability:_____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Patient Signature_____Date_____

Guardian Signature_____Date_____

ADVANCED SPINE
REHAB CENTER

Functional Rating Index

For use with **Neck** and/or **Back** related problems only.
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 below, please circle the one choice which most closely describes your condition right now.

1. Pain Intensity

No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

No pain no restrictions	Mild pain no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

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

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. Recreation

No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

7. Frequency of Pain

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

No pain w/heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

No pain any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name _____ Total Score _____
Printed

_____ _____
Signature Date