



INSPIRE CHIROPRACTIC
HEALING OUR COMMUNITY

NEW PRACTICE MEMBER APPLICATION

Name: _____ Date of Birth: ____/____/____ Age: _____ Male Female
Address: _____ City: _____ State: _____ Zip: _____
Phone: Cell _____ Home _____
Email Address: _____ Social Security #: _____
Occupation: _____ Employer: _____
Status: Single Married Divorced Widowed - Spouse's Name: _____ # of Children: _____
Names, Ages, & Gender: _____
Who may we thank for referring you? _____

LIST THE HEALTH CONCERNS THAT BROUGHT YOU INTO THIS OFFICE BELOW

Health Concern: (List according to severity)	Rate of severity 0 = no pain 10 = unbearable	When did this problem start?	Have you had the problem before? If so, when?	Did the problem begin with an injury?	Are symptoms Constant (C) Intermittent (I)?
First: _____	_____	_____	_____	_____	_____
Second: _____	_____	_____	_____	_____	_____
Third: _____	_____	_____	_____	_____	_____
Fourth: _____	_____	_____	_____	_____	_____

Have you seen other doctors for these conditions? Yes No

If Yes: Chiropractor Medical Doctor Other: _____
Who? _____ When? _____ Results? _____

Please Mark "P" For In The Past OR Mark "C" For Currently Have:

- ___ Headaches ___ Ear Infections ___ Sinus Issues ___ Kidney Problems ___ Sexual Dysfunction
- ___ Migraines ___ Hearing Loss ___ Frequent Colds ___ Bladder Problems ___ Sleep Problems
- ___ Jaw/TMJ Pain ___ Ringing in the Ears ___ Thyroid Issues ___ Menstrual Problems ___ Tight/Sore Muscles
- ___ Neck Pain ___ Dizziness ___ Asthma ___ Prostate Problems ___ Sports Injury
- ___ Shoulder Pain ___ Loss of Energy ___ Chest Pain ___ Infertility ___ Sciatica
- ___ Arm Pain ___ Nervousness ___ Heart Problems ___ Fibromyalgia ___ Arthritis/Joint Pain
- ___ Upper Back Pain ___ Double/Blurry Vision ___ Nausea ___ Epilepsy/Convulsions ___ GERD/Gastric Reflux
- ___ Mid Back Pain ___ Anxiety ___ Ulcers ___ Tremors ___ Numb/Tingling in Arms/Hands
- ___ Lower Back Pain ___ ADD/ADHD ___ Digestive Issues ___ Disc Problems ___ Numb/Tingling in Legs/Feet
- ___ Hip/Leg Pain ___ Loss of Balance ___ Diarrhea ___ Scoliosis ___ Stomach Problems
- ___ Knee Pain ___ Depression ___ Constipation ___ Poor Posture ___ High/Low Blood Pressure
- ___ Foot Pain ___ Allergies ___ Bed Wetting ___ Skin Problems ___ Difficulty Breathing

Pregnant? Yes No If yes, Due Date? _____

Other(s): _____
___ Stroke ___ Cancer ___ Heart Attack ___ Spinal Surgery ___ Diabetes
___ Spinal Bone Fracture ___ Scoliosis ___ Arthritis ___ Seizures Other: _____

PLEASE MARK the areas on the diagram with the following LETTER(S) to describe your symptoms:

- R=** Radiating **B=** Burning **D=** Dull **A=** Aching
N= Numbness **S=**Sharp/Stabbing **T=**Tingling

What relieves your symptoms? _____

What makes them feel worse? _____

When is (are) the problem(s) at its worst? AM PM Mid-Day Late PM

List all surgical operations & years: _____

List any other injuries to your spine, minor or major, that the doctor should know about: _____

List all over the counter & prescription medications you are on, & the reason for each: _____

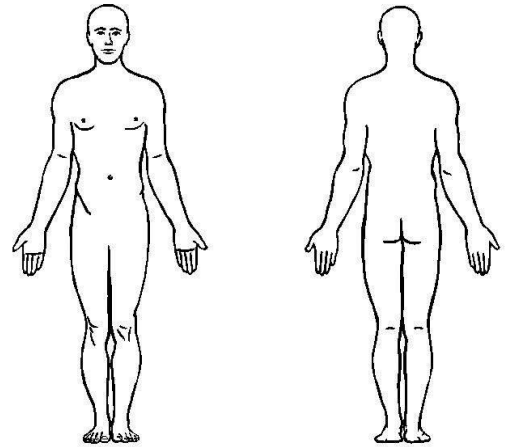
Have you ever been in an auto accident? List all: _____

Have you ever been knocked unconscious? Yes No

Fractured A Bone? Yes No

If yes to either of the above, please describe: _____

Other trauma: _____



Social History

- Smoking: How Often? Daily Weekends Occasionally Never
- Alcohol: How Often? Daily Weekends Occasionally Never
- Exercise How Often? Daily Weekends Occasionally Never
- Have you consumed any caffeine or products with caffeine in the past 48 hours? Yes No

Quadruple Visual Analogue Scale

Please circle the number that best describes the question asked. If you have more than one complaint, please answer each question for each individual complaint and indicate the score of each complaint.

EXAMPLE: No Pain _____ **Back pain** _____ **Headaches** _____ Worst Possible Pain _____
0 1 2 3 4 **5** 6 7 **8** 9 10

1. How would you rate your pain RIGHT NOW?

0 1 2 3 4 5 6 7 8 9 10

2. What is your typical or AVERAGE pain?

0 1 2 3 4 5 6 7 8 9 10

3. What is your pain level at its BEST? (How close to 0 does your pain get at its best?)

0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain at its best? _____%

4. What is your pain level at its WORST? (How close to 10 does your pain get at its worst?)

0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain at its worst? _____%

PLEASE PRINT NAME HERE

DATE

FOR OFFICE USE: Q1 _____ + Q2 _____ + Q4 _____ = _____ / 3x10= _____

ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITY:

EFFECT:

Sit to Stand	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Carry Groceries	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Climbing Stairs	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Pet Care	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Driving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Extended Computer Use	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Household Chores	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Lifting Children	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Dressing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sexual Activities	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sleeping	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Static Sitting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Static Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Walking	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Washing/Bathing/Shaving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sweeping/Vacuuming	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Yard work	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Garbage	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Concentration (Reading)	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Other_____	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform

WHAT ARE YOU HOPING TO ACHIEVE WHILE UNDER CARE?

HEALTH GOAL

SIGNIFICANCE OF GOAL

EXAMPLE: Goal: Get rid of my headaches

I want to play with my kids without pain, be able to spend more time with my family and have more energy

1. _____

2. _____

3. _____

PLEASE PRINT NAME HERE

DATE

FAMILY HEALTH HISTORY

THIS FORM IS TO ASSIST THE DOCTORS BY PROVIDING PAST HEALTH HISTORY INFORMATION FOR THEIR REVIEW.

CONDITION	SPOUSE	SON	DAUGHTER	MOTHER	FATHER
Headaches					
Neck Pain					
Jaw/TMJ Pain					
Shoulder Pain					
Back Pain					
Hip/Leg Pain					
Arthritis/Joint Pain					
Ear Infections					
Hearing Loss					
Dizziness					
Loss Of Energy					
Nervousness					
Blurred/Double Vision					
Anxiety					
ADD/ADHD					
Depression					
Allergies					
Sinus Issues					
Thyroid Problems					
Asthma					
Breathing Problems					
Heart Problems					
High/Low Blood Pressure					
Stomach Problems					
Bed Wetting					
Infertility					
Sciatica					
Fibromyalgia					
Poor Posture					
Sleep Problems					
Stroke					
Cancer					
Heart Disease					
Diabetes					
Arthritis					
Alzheimer's					

PLEASE PRINT NAME HERE

DATE

INFORMED CONSENT FOR CHIROPRACTIC CARE

Chiropractic care, like all forms of health care, while offering considerable benefits may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases, injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include: sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral injury that could lead to a stroke.

Prior to receiving chiropractic care in this chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific conditions, your overall health and in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

- I understand and accept that there are risks associated with chiropractic care and give consent to the examination that the doctor deems necessary and the chiropractic care, including spinal adjustments, as reported following my assessment.
- I authorize and request payment of insurance benefits directly to Shaheryar Khan, D.C. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the practice member. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

PRINT NAME

PRACTICE MEMBER'S SIGNATURE OR GUARDIAN SIGNATURE

DATE

IF THIS HEALTH PROFILE IS FOR A MINOR/CHILD, PLEASE FILL OUT AND SIGN BELOW

WRITTEN CONSENT FOR A CHILD

Name of practice member who is a minor/child: _____

I authorize Dr. Shaheryar Khan and any and all Inspire Chiropractic staff to perform diagnostic procedures, radiographic evaluations, render chiropractic care, and perform chiropractic adjustments to my minor/child. As of this date, I have the legal right to select and authorize health care services for my minor/child. If my authority to select and authorize care is revoked or altered, I will immediately notify Inspire Chiropractic.

GUARDIAN SIGNATURE

DATE

RELATIONSHIP TO MINOR/CHILD

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

1. Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physician's certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

SIGNATURE

DATE

X-RAY AUTHORIZATION

As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files. At your request, we will provide you with a copy of your x-rays in our files. There is no fee for a requested copy of x-rays. However, advanced notice is appreciated. Digital x-rays on a CD will be available within 72 hours of request on any regular practice hours day. Please note: X-rays are utilized in this office to help locate and analyze vertebral subluxations. The doctor of Inspire Chiropractic does not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice.

By signing below, you are agreeing to the above terms and conditions..

PRINT NAME HERE

DATE OF BIRTH

SIGNATURE

DATE

FEMALES ONLY: To the best of my knowledge, I BELIEVE I AM NOT PREGNANT at the time the x-rays are taken at Inspire Chiropractic.

SIGNATURE

DATE